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Supreme Court, U.S.
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No. (1)

# In the Supreme Court of the United States

RUTH AROCHO, As Administratrix of the ESTATE OF ENRIQUE RENE VERAS, WADAYS VERAS, and RUTH AROCHO As Parent and Natural Guardian of Crystal Veras,and Yashera Veras
*Petitioners*

-vs-

COUNTY OF LEHIGH and DALE MEISEL,
*Respondents*

**On Petition for Writ of Certiorari to The Supreme Court of Pennsylvania**

## PETITION FOR WRIT OF CERTIORARI AND APPENDIX VOLUME I

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## QUESTIONS PRESENTED

This Court defined "deliberate indifference" for purposes of an Eighth Amendment violation as "know[ing] that inmates face a substantial risk of serious harm and disregard[ing] that risk by failing to take reasonable measures to abate it." The Pennsylvania Courts held that the test of reasonableness required actual knowledge by prison officials that the measures were unreasonable, and applied a blanket prohibition to the introduction of prevailing corrections standards.

The questions submitted for review are

1. Whether *Farmer v. Brennan* applies a standard of objectively reasonable to the measures taken to abate a known risk of harm?

2. Whether this Court's decision in *Bell v. Wolfish* precludes consideration of industry standards as part of the quantum of evidence that the response to a known risk was unreasonable?

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## CITATIONS TO THE OFFICIAL AND UNOFFICAL REPORTS OF THE OPINIONS AND ORDERS ENTERED IN THIS CASE

On April 26, 2006, the Court of Common Pleas, Lehigh County granted Defendants' Motion for Summary Judgment in an unreported opinion. On May 3, 2007, the Commonwealth Court of Pennsylvania affirmed the Court of Common Pleas. 922 A.2d 1010; 2007 Pa. Commw. LEXIS 197 (Pa. Cmwlth. 2006). On January 30, 2008, the Supreme Court of Pennsylvania denied Petitioner's Petition for Allowance of Appeal at No. 442 MAL 2007, 2008 Pa. LEXIS 31 (Pa. January 30, 2008).

## STATEMENT OF THE BASIS FOR THE JURISDICTION

The United States Supreme Court has jurisdiction over this matter pursuant to Supreme Court Rule 10(b). The Pennsylvania Supreme Court had jurisdiction over a Petition for Allowance of Appeal pursuant to 42 Pa.C.S.A. § 724(a) and Pa.Rule.App.Proc. 1112 as an appeal from a final order of the Commonwealth Court. The Commonwealth Court had jurisdiction over an appeal from the final order of the Court of Common Pleas of Lehigh County, Pennsylvania granting Summary Judgment in favor of Lehigh County and Warden Dale Meisel pursuant to 42 Pa.C.S.A. § 762.

## CONSTITUTIONAL PROVISIONS, TREATIES, STATUTES, ORDINANCES, AND REGULATIONS INVOLVED IN THE CASE

**42 U.S.C.§ 1983. Civil action for deprivation of rights**

Every person who, under color of any statute, ordinance, regulation, custom, or usage, of any State or Territory or the District of Columbia, subjects, or causes to be subjected, any citizen of the United States or other person within the jurisdiction thereof to the deprivation of any rights, privileges, or immunities secured by the Constitution and laws, shall be liable to the party injured in an action at law, suit in equity, or other proper proceeding for redress, except that in any action brought against a judicial officer for an act or omission taken in such officer's judicial capacity, injunctive relief shall not be granted unless a declaratory decree was violated or declaratory relief was unavailable. For the purposes of this section, any Act of Congress applicable exclusively to the District of Columbia shall be considered to be a statute of the District of Columbia.

**Eighth Amendment to the United States Constitution**

Excessive bail shall not be required, nor excessive fines imposed, nor cruel and unusual punishments inflicted.

**Fourteenth Amendment to the United States Constitution**

Sec. 1. All persons born or naturalized in the United States, and subject to the jurisdiction thereof, are citizens of the United States and of the State wherein they reside. No State shall make or enforce any law which shall abridge the privileges or immunities of citizens of the United States; nor shall any State deprive any person of life, liberty, or property, without due process of law; nor deny to any person within its jurisdiction the equal protection of the laws.

* * *

Sec. 5. The Congress shall have the power to enforce, by appropriate legislation, the provisions of this article.

## STATEMENT OF THE CASE

1. In February of 2002 Enrique Veras was incarcerated and immediately placed on "suicide precaution" status. On February 11, 2002 Mr. Veras attempted suicide in his cell by hanging, and after spending six weeks in disciplinary segregation as punishment for the attempt, was returned to "suicide precaution" status on March 30, 2002 and remained on this status until he was released from Lehigh County Prison on April 2, 2002.

Enrique Veras returned to Lehigh County Prison on October 27, 2002, at which time he was placed on "suicide precaution" status, based on a medical assessment that stated "BE ABSOLUTELY WATCHFUL OF HIS BEHAVIOR. CONSIDER THIS PATIENT HIGH RISK FOR REPEATED SELF-INJURY. MUST HAVE SOMEONE WATCHING HIM AT ALL TIMES." [emphasis in original].

The next day, again while on suicide precautions, Mr. Veras fashioned a noose from bedding, and was found hanging from the cell bars. The nurse that responded opined "he's gone," but in fact Mr. Veras remained conscious and was placed in a "restraint chair." After two and a half hours, he was released from the restraint chair and remained on suicide precautions.

On November 4, 2002, Enrique Veras was transferred to the Mental Health Unit and remained

on "suicide precaution" status. Enrique Veras was removed from "suicide precaution" status on November 14, 2002, when he was transferred to disciplinary segregation as a result of his October 28 suicide attempt.

Mr. Veras was released from segregation on December 4, 2002, and began to engage in self-injurious behavior. Consequently, he was placed in a "suicide precaution cell", specifically Cell 3223 that is located in the Administrative/Disciplinary Segregation Unit. A Corrections officer in a booth in the unit is responsible for monitoring the inmate on suicide precautions, but the view is either partially or completing obscured by a staircase, depending on where the officer is standing in the booth.

Immediately upon being placed in the cell in 3C1, Mr. Veras began engaging in self-injurious behavior, including trying to hang himself by tying his underwear around his neck and to the towel bar in the cell. Mr. Veras was given a blanket and was stripped naked, and upon authorization from the medical department, was placed in a restraint chair between 8:45 P.M. and 9:00 P.M.. Between 10:30 P.M. and 10:45 P.M., correctional officers attempted to remove the Enrique Veras from the restraint chair, but he refused to leave the restraint chair, stating that he would harm himself if he were removed. He was therefore left in the restraint chair.

Mr. Veras remained on suicide precautions until the time of his death, sixteen hours later. On December 5, 2002 at approximately 4:10 P.M., Enrique Veras was found in Cell 3223 hanging in his

cell from the bars. The ligature was characterized as bed linen or a sheet. He was transferred to the hospital where he was pronounced dead.

2. Lehigh County Prison has a suicide prevention policy [Appendix 64-66] which states that the facility will "provide special housing, increased levels of observation, and medical restraint to those inmates who display self-destructive behavior." The Lehigh County Prison suicide prevention policy was based upon standards separately promulgated by the American Correctional Associate (ACA) and the National Commission on Correctional Health Care (NCCHC). The County has never contended that these standards are not applicable to them.

The ACA standard mandates constant observation for suicidal inmates. The NCCHC standards require that an inmate assessed as a high suicide risk be observed on a "continuing, uninterrupted basis or be transferred to an appropriate health facility." [Appendix p. 69, ¶ 5].

According to the references section of the Lehigh County Prison policy, a National Corrections Institute Publication was also consulted. That publication is a report prepared by Lindsay Hayes, Plaintiff's expert in this case. Director Sweeney reviewed Lindsay Hayes' publications in the process of issuing the Lehigh County Prison Suicide Prevention policy. The recommendations in that report echo the NCCHC requirements for continuous observation of actively suicidal inmates on a one-on-one basis, either by a member of the corrections staff or a fellow inmate.

The Lehigh County Prison policy does not require constant observation of inmates at high risk of suicide, nor does the policy on its face even provide for the possibility of constant observation. Director Sweeney, who considered the ACA and NCCHC standards when he issued the policy, had no explanation for why the standards for constant observation were omitted from the policy. He stated that there was no penological justification for omitting this.

3. The NCCHC standard requires that a cell designated for suicide prevention "be as nearly suicide-proof as possible (i.e. without protrusions of any kind that would enable the inmate to hang him/herself." However, Director Sweeney has admitted that the cells used as "suicide prevention" cells at Lehigh County Prison are not suicide resistant in that there are multiple ligature anchor points accessible to the inmate, and that he was aware of this deficiency.

The Lehigh County Prison policy provides for only two levels of observation for suicidal inmates: suicide precautions and close observation. The policy also provides for medical restraint (ie. the "restraint chair") as a temporary measure. The policy does not delineate any difference between the monitoring of inmates in the two levels, and the deposition testimony of all of the witnesses reveals that the only difference is whether the inmate is maintained clothed or stripped naked.

The suicide prevention cells at Lehigh County Prison all have open face bars, towel bars, and clothing hooks, all of which are easily recognizable ligature anchor points. Director Sweeney understood that the cells with open faced bars, including the one in which Mr. Veras committed suicide, are not safe for suicidal inmates in that the open bar cells provide multiple ligature points. Director Sweeney stated that an open bar cell is not suicide resistant, since "obviously . . . someone could certainly tie something to the door." Director Sweeney also understood that that there are no suicide resistant cells at the Lehigh County Prison.

4. The Federal questions sought to be reviewed were raised as integral parts of Petitioner's claims in their Complaint. [Appendix 97-106]. The questions were initially passed upon by the Court of First Instance, the Court of Common Pleas of Lehigh County, Pennsylvania, upon Respondents (Defendants below) Motion for Summary Judgment. That motion was denied. *See* Appendix p. 35-36. The issues were reconsidered by the Court of Common Pleas on Respondent's Motion, and were disposed by the Court's opinion. [Appendix 34-63]. The entirety of that opinion, except for those portions addressing matters of state civil procedure, is addressed to the issues for which review is sought. The matters were raised before the Commonwealth Court of Pennsylvania by Petitioner's appeal, and were addressed in the opinion of the Commonwealth Court. [Appendix 2-33]. The entirety of that opinion, except for those portions addressing matters of state civil procedure, is addressed to the issues for which review is sought. The questions were the subject of a

Petition for Allowance of Appeal [Appendix 107 *et seq.*] to the Pennsylvania Supreme Court, which was denied without opinion. [Appendix 1].

## REASONS RELIED UPON FOR ALLOWANCE OF THE WRIT

1. This is a case that will permit the Supreme Court to discretely define the contours of the second part of the *Farmer* definition of "deliberate indifference," since the subjective knowledge of risk element was not at issue in the State Courts. Rather, the only question was what the Court should consider in determining whether the response was reasonable.

2. This Court has held that a prison official may be liable under 42 U.S.C. § 1983 if he was subjectively aware that an inmate faced a substantial risk of serious harm and disregarded that risk by failing to take reasonable measures to abate it. *Farmer v. Brennan*, 511 U.S. 825, 847 (1994). In this case, the record is clear that Enrique Veras faced a substantial risk of serious harm from suicide. Lehigh County conceded not only that Mr. Veras had a peculiar risk of suicide, but that the prison officials knew that he did. Under *Farmer*, the only remaining question was whether Lehigh County Prison failed to take reasonable measures to abate the risk to Mr. Veras.

3. Rather than follow the clear directions of this Court, the Court of Common Pleas, Commonwealth Court – and ultimately the Pennsylvania Supreme

Court, by denying allocatur – embarked upon two additional enquiries:

> *First*, whether the general record of suicides and suicide attempts at the Lehigh County Prison put the prison officials on notice of the need for different suicide precautions; and
>
> *Second*, whether the prison official subjectively appreciated that the suicide prevention policies posed a substantial risk of serious harm.

4. The first enquiry was improper because *Farmer* set up two distinct methods of proof as to whether there was a substantial risk of harm from suicide: one enquiry when the prison officials did not have actual notice of a peculiar risk to a particular inmate; and a separate enquiry where the prison officials had recognized that a particular inmate was at risk of suicide. The tests, while not mutually exclusive, are nonetheless separate and distinct, and a § 1983 Plaintiff need satisfy only one in order to prevail. In this case, Lehigh County Prison officials had recognized that Enrique Veras was at imminent risk of suicide, and had placed him on suicide precautions. At the time of his death by suicide, he had been on suicide precautions for approximately eighteen hours. There was no need to further enquire into whether there was a general risk at the prison.

5. The second enquiry was improper because the subjective appreciation standard in *Farmer* applies only to the initial question of whether the prison officials "drew the inference" that the inmate was at substantial risk, and not the second question of whether the prison officials took reasonable steps to abate the harm.

6. The record supported the conclusion that Lehigh County Prison knew that the provisions that it made for housing suicidal inmates was not proper, and therefore that the precautions were not reasonable. The lower courts erred in deciding the question of reasonableness as a matter of law, and also erred in completely disregarding the uncontested opinion of Plaintiff's expert, Lindsay Hayes, that the Lehigh County Prison procedures were contrary to prevailing correctional standards, and constitutionally infirm.

7. This Court has imposed § 1983 liability in a conditions of confinement case where the prison officials are "deliberately indifferent" to the inmates peculiar vulnerability to suicide. The controlling decision by this Court defines the standard as "a prison official may be held liable under the Eighth Amendment for denying humane conditions of confinement only if he knows that inmates face a substantial risk of serious harm and disregards that risk by failing to take reasonable measures to abate it." *Farmer v. Brennan*, 511 U.S. 825, 847 (1994).

In *Farmer*, this Court parsed the first requirement into two subparts,

> (1) the detainee had a particular vulnerability to suicide; and
>
> (2) the custodial officer or officers knew of that vulnerability

511 U.S. at 836 ("the official must both be aware of facts from which the inference could be drawn that a substantial risk of serious harm exists, and he must also draw the inference"). The *Farmer* opinion equates the last factor with a breach of duty. 511 U.S. at 845 ("Whether one puts it in terms of duty or deliberate indifference, prison officials who act reasonably cannot be found liable under the Cruel and Unusual Punishments Clause.")

This Court explained that the term "deliberate indifference" lies "somewhere between the poles of negligence at one end and purpose or knowledge at the other." *Farmer*, 511 U.S. at 836. It is by this standard – and only this standard – that the Lower Courts were required to consider this case. The State Courts erred by misunderstanding that the holdings of pre-*Farmer* cases were still applicable.

8. In this case, Lehigh County Prison and Warden Meisel conceded that they had subjective knowledge that Enrique Veras was at substantial risk of death by suicide. Therefore, the only question was whether they took reasonable steps to abate the known risk.

9. The State Courts did not recognize that there is both an objective and a subjective component to a deliberate indifference claim – Did the prison

official have *subjective* knowledge of a peculiar or general risk; and were the measure taken to abate the risk *objectively* reasonable. *Farmer*, 511 U.S. at 846 ("to survive summary judgment, he must come forward with evidence from which it can be inferred that the defendant-officials were at the time suit was filed, and are at the time of summary judgment, knowingly and unreasonably disregarding an objectively intolerable risk of harm"); *See also Montgomery v. Pinchak*, 294 F.3rd 492, 499 (3rd Cir. 2002).

The only question at issue in this case was the second question: whether the Lehigh County Prison failed to take objectively reasonable steps to abate the danger to Enrique Veras. *Farmer*, 511 U.S. at 847 ("a prison official may be held liable under the Eighth Amendment for denying humane conditions of confinement only if he knows that inmates face a substantial risk of serious harm and disregards that risk by failing to take reasonable measures to abate it.") The factor that defines where an act or omission falls on the continuum between negligence and intent is where the prison official subjectively perceives that an inmate is at risk. Once that degree of knowledge is achieved, the prison is bound to provide an objectively reasonable abatement.

10. The State Courts placed great emphasis on the lack of a significant history of prior suicides at the Lehigh County Prison. [Appendix 10-11, 23-24] Under *Farmer*, the record of prior suicides and suicide attempts may be relevant to the subjective knowledge enquiry, but only if there was no evidence of subjective knowledge of a particular vulnerability

to suicide of the inmate in question. *Farmer*, 511 U.S. at 842-43. Since there is no question that the prison and its top officials had actual knowledge of Mr. Veras' particular vulnerability, the prior record (or lack thereof) of suicide attempts is not a proper consideration. Even if this was a proper consideration, that consideration would be for the fact-finder in determining the reasonableness of the response, and not for the Court.

11. The Commonwealth Court also erred in requiring proof of *scienter*. [Appendix p. 23]. In so holding, the Commonwealth Court mistakenly relied upon the opinion of the Court of Appeals for the Third Circuit in *Simmons v. City of Philadelphia*, 947 F.2d 1042, 1060-1061, n. 13 (3rd Cir. 1991). However, this Court repudiated such a requirement in *Farmer*. The standard of purposeful or knowing conduct is not necessary to satisfy the requirement of deliberate indifference. *Id.* at 836. This Court further clarified that it did not intend to require a plaintiff to show intent to harm on the part of the prison, nor did it require direct evidence of the prison's knowledge of the vulnerability. *Farmer*, 511 U.S. at 842. Nor must an Eighth Amendment claimant show that a prison official acted or failed to act believing that harm actually would befall an inmate; it is enough that the official acted or failed to act despite his knowledge of a substantial risk of serious harm. *Id.*.

12. The State Courts also held that the prison was effectively immunized from liability by delegating decisions on housing assignments to its contracted medical provider, based upon *Spruill v. Gillis*, 372 F.3rd 218 (3rd Cir. 2004). [Appendix p. 56-

57]. In *Spruill*, the Court of Appeals held that non-medical prison staff may rely on the medical treatment being given by the medical staff. However, the issue in *Spruill* was whether an inmate was receiving proper medical care for an injury, not whether the prison had proper housing facilities and inmate monitoring policies. Neither the facts in that case, nor the Court's decision, suggest application of this rule to any security or housing issues.[1]

This standard should be inapplicable to a claim relating to conditions of confinement. Mr. Veras clearly suffered from a serious medical condition, and was being treated by prison medical

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[1] Indeed, the cases that have relied upon the substantive issue of the *Spruill* case, namely the liability of prison officials for medical decisions (as opposed to the administrative exhaustion issue), have been cases where a dispute has arisen over the quality of medical treatment for discrete illness or injury, and not conditions of confinement. *See* e.g. *Anderson v. Bureau of Prisons*, 2006 U.S. App. LEXIS 9034 (3d Cir. 2006)(defendants misdiagnosed his knee and back pain and provided "conservative" treatments that were ineffective); *Wall v. Dauphin County*, 2006 U.S. App. LEXIS 3732 (3rd Cir. 2006)(licensed nurse began treating inmate as soon as he collapsed); *Brooks v. Beard*, 2006 U.S. App. LEXIS 3494 (3d Cir. 2006)(medical decisions regarding follow-up visits to the specialist and physical therapy); *Catchings v. Marrow*, 160 Fed. Appx. 256, 258 (3rd Cir. 2005)(prescription decision); *Thomas v. Dragovich*, 142 Fed. Appx. 33, 37 (3rd Cir. 2005)(prison knew that medical department had denied treatment yet "failed to help"); *Jones v. Falor*, 135 Fed. Appx. 554, 555 (3rd Cir. 2005)(adequate course of medical treatment for a left knee injury); *Vile v. Klem*, 131 Fed. Appx. 386, 388 (3rd Cir. 2005)(injuries sustained during surgical procedure); *Ali v. Terhune*, 113 Fed. Appx. 431, 434 (3d Cir. 2004)(medical staff also chose simply to administer generic pain relievers, rather than send Plaintiff for a surgical procedure).

staff. However, that staff did not make any recommendations, nor issue any orders with respect to the conditions under which Mr. Veras would be housed. Lehigh County Prison conceded that it does not routinely provide constant observation, but argues that it will be provided if there is a specific medical order. Lehigh County Prison also contended that the medical contractor's policies supplement the Lehigh County Prison policies.

However, the contractor's policy assumed that constant observation will be provided to inmates on suicide precautions. That policy states that potentially suicidal inmates will be "placed in area designated by security to permit close observation." [emphasis added]. [Appendix 75, ¶ 5(b)]. The NCCHC standards define "close observation" as constant observation. [Appendix 69, ¶ 5]. Lehigh County Prison has no official policy delegating any housing questions to the contractor, and no official policy that provides for constant observation under any circumstances. [Appendix 64-66]. The allocation of the burden for setting housing conditions on the medical contractor has been identified by Plaintiffs' expert as a willful indifference to the suicidal inmate.

13. The State Courts impermissibly linked municipal liability under Section 1983 to proof that a municipal actor is liable for a constitutional tort. In this case, the Commonwealth Court engaged in an extensive analysis of the liability of Warden Meisel, [Appendix p. 17-27], ultimately holding that Warden Meisel was not liable under §1983. The Court then disposed of the claim against Lehigh County, holding that

> This Court has expressly adopted the *Trigalet* analysis. ("We hold, therefore, that in the absence of an underlying unconstitutional action by employees of the City . . ., we will not consider the question of whether the City [has liability] . . ."); (accepting the "reasoning of the vast majority of federal circuits, which adopt the general rule that a municipality cannot be liable unless there is a constitutional violation by the municipal actor causing the plaintiff's harm"). [Internal citations omitted]

[Appendix p. 29-30].

The Commonwealth Court recited the *"Trigalet"* analysis (from *Trigalet v. City of Tulsa*, 239 F.3d 1150, 1155 (10th Cir. 2002) as

> a municipality cannot be held liable in a *Section 1983* action in the absence of a predicate unconstitutional act by the municipality's employee. Even if the municipality's actions are arbitrary or even "conscience shocking, in a constitutional sense" the municipality cannot be held liable under § 1983. This is because a claim of "inadequate training [or] supervision . . . under §1983 cannot be made out against a supervisory authority absent a finding of a constitutional violation by the

> person supervised." [Internal citations omitted].

*Id.*

This is an accurate statement of the law, as the Third Circuit recognized in *Brown v. Pa. Dep't of Health Emergency Med. Servs. Training Inst.*, 318 F.3rd 473, 482-483 (3rd Cir. 2003), but the Pennsylvania Courts did not apply this rule properly. A municipality may be held independently liable for a substantive due process violation even in situations where none of its employees are liable, but have nonetheless violated plaintiff's constitutional rights, *Collins v. City of Harker Heights*, 503 U.S. 115, 122, (1992) (emphasizing "the separate character of the inquiry into the question of municipal responsibility and the question whether a constitutional violation occurred."). Indeed, in *Farmer*, 511 U.S. at 841 this Court held that allegations that individual officers violated Eighth Amendment rights are examined using a *subjective* awareness standard while allegations of municipal misconduct receive an *objective* analysis).

14. "[I]t is when execution of a government's policy or custom . . . inflicts the injury that the government as an entity is responsible under § 1983." *Monell v. Department of Soc. Servs.*, 436 U.S. 658, 694, (1978). There is municipal liability for a policy or practice that is the "direct cause" or "moving force" behind the constitutional violation. *See City of Oklahoma v. Tuttle*, 471 U.S. 808, 820 (1985); *City of Canton*, 489 U.S. at 385; *Monell*, 436 U.S. at 691. A constitutional injury caused by a municipality may

be shown directly by demonstrating that the policy itself is unconstitutional. *See id.* at 694-95 (holding that a municipality may be liable under § 1983 for a policy that requires pregnant women to take unpaid leave before leave was required for medical reasons because the policy itself is unconstitutional).[2]

15. The State Courts misapplied the decision of this Court in *Bell v. Wolfish*, 441 U.S. 520 (1979), essentially as a *per se* rule against the consideration of evidence of prevailing industry standards. [Appendix 20; 62 n.15]. This Court has recently disapproved such *per se* rules in *Fed. Express Corp. v. Holowecki*, ___ U.S. ___, 28 S. Ct. 1147, 170 L. Ed. 2d 10 (2008).

Plaintiff offered the expert opinion of Mr. Lindsay Hayes, perhaps one of the foremost experts in the United States in the field of Prison suicide prevention. [Appendix 76-96]. Hayes was highly critical of the Lehigh County suicide prevention policy on the basis of a lack of continuous visibility of the "suicide prevention" cell, the availability of ligature anchor points, including the open cell bars, and absence of the option of continuous observation. Mr. Hayes deemed these conditions "one the worst cases [he had] reviewed in the past 25 years" from the perspective of suicide prevention. The Pennsylvania Courts refused to consider this opinion

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[2] Petitioner does not argue, as the Commonwealth Court mistakenly believed, that a municipality has *Monell* liability in the absence of a constitutional violation, as the Third Circuit once held in *Fagan v. City of Vineland*, 1993 U.S. App. LEXIS 20327 (3rd Cir. 1993), *aff'd* 22 F.3rd 1296 (3rd Cir. 1994)(*en banc*). This was clearly repudiated in *Brown*.

since it was derived by reference to prevailing published standards.

In *Bell*, this Court held that published standards for prison conditions, while not determinative of constitutional requirements, may be instructive as the accepted standards for prison conditions. 441 U.S. at 543 n. 27. While NCCHC and ACA standards are not binding standards, they are certainly evidence of what are reasonable steps to abate the risk of suicide. *Id.*; *Gates v. Cook*, 376 F.3rd 323 (5th Cir. 2004) (ACA accreditation and compliance with standards are relevant considerations but not dispositive of compliance with the Eighth Amendment).

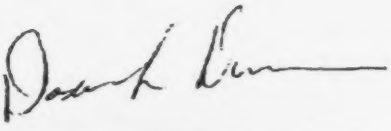
In fact, the Lehigh County Prison suicide prevention policy is based upon both sets of standards, but follows neither. The prison was not able to explain its decision not to follow the standards. This raises a clear question of whether the decision – the product of deliberation – was reasonable. An unreasonable decision which is the product of deliberation is "deliberate indifference." *Pembaur v. City of Cincinnati*, 475 U.S. 469, 483-84 (1986)("municipal liability under § 1983 attaches where a deliberate choice to follow a course of action is made from among various alternatives by the official or officials responsible for establishing final policy with respect to the subject matter in question.")

## CONCLUSION

The Court of Common Pleas once recognized that this is not a case which is clear and free from doubt as to whether the Lehigh County Prison and Warden Meisel acted reasonably in response to a known risk of serious injury. This was the correct decision. Thereafter, this case took a tortuous route, made even more convoluted by the errors discussed herein. This Petition for Writ of Certiorari requests that the Supreme Court correct the errors of law perpetuated by the State Courts, and clarify the standard to be applied in the second prong of the *Farmer* definition in the interest of all future inmates who are threatened by suicidal ideation.

Respectfully submitted,

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Dated: April 25, 2008

RUTH AROCHO, AS ADMINISTRATRIX OF THE ESTATE OF ENRIQUE RENE VERAS AND WADAYS VERAS AND RUTH AROCHO AS PARENT AND GUARDIAN OF CRYSTAL VERAS AND YASHERA VERAS, Petitioners v. COUNTY OF LEHIGH AND DALE MEISEL, Respondents

No. 442 MAL 2007

SUPREME COURT OF PENNSYLVANIA

2008 Pa. LEXIS 31

January 30, 2008, Decided

**NOTICE:** DECISION WITHOUT PUBLISHED OPINION

**PRIOR HISTORY:** [*1]
Petition for Allowance of Appeal from the Order of the Commonwealth Court.
Arocho v. County of Lehigh, 922 A.2d 1010, 2007 Pa. Commw. LEXIS 197 (Pa. Commw. Ct., 2007)

***ORDER***

**PER CURIAM**

**AND NOW**, this 30th day of January, 2008, the Petition for Allowance of Appeal is **DENIED**.

LEXSEE

**Ruth Arocho, As Administratrix of the Estate of Enrique Rene Veras and Wadays Veras and Ruth Arocho as Parent and Guardian of Crystal Veras and Yashera Veras, Appellants v. County of Lehigh and Dale Meisel**

**No. 1008 C.D. 2006**

COMMONWEALTH COURT OF PENNSYLVANIA

*2007 Pa. Commw. LEXIS 197*

**December 13, 2006, Argued**
**May 3, 2007, Decided**
**May 3, 2007, Filed**

**PRIOR HISTORY:** [*1] Appealed from No. 2003-C-3235. Common Pleas Court of the County of Lehigh. Judge Brenner, J.

**DISPOSITION:** AFFIRMED.

**COUNSEL:** David L. Deratzian, Bethlehem, for appellants.

Rudolph Zieger, Allentown, for appellees.

**JUDGES:** BEFORE: HONORABLE JAMES GARDNER COLINS, President Judge, HONORABLE BERNARD L. McGINLEY, Judge, HONORABLE

DAN PELLEGRINI, Judge, HONORABLE BONNIE BRIGANCE LEADBETTER, Judge, HONORABLE RENEE COHN JUBELIRER, Judge, HONORABLE ROBERT SIMPSON, Judge, HONORABLE MARY HANNAH LEAVITT, Judge. OPINION BY JUDGE LEAVITT.

**OPINION BY:** MARY HANNAH LEAVITT

**OPINION:** OPINION
BY JUDGE LEAVITT

The children and estate (Estate) of Enrique Veras (Decedent), n1 who committed suicide while incarcerated at the Lehigh County Prison (Prison) on December 5, 2002, appeal a judgment of the Court of Common Pleas of Lehigh County (trial court). By this judgment, the trial court held that the Estate could not sustain its *42 U.S.C. § 1983* action for damages against Dale Meisel, the Prison Warden, or against Lehigh County for their alleged violations of Decedent's constitutional rights. In this case we consider whether the trial court erred by holding, as a matter of law, that neither Meisel nor Lehigh **[*2]** County acted with "deliberate indifference" to Decedent's particular vulnerability to suicide while he was incarcerated in the Prison.

n1 Appellant Ruth Arocho is the administratrix of Decedent's estate and the mother of Decedent's minor children, Crystal Veras and Yashera Veras. Appellant Wadays Veras is Decedent's adult child.

**Suicide Prevention Policy**

Because it is central to the outcome of this case, we begin with an overview of the Prison's Suicide Prevention Policy (Policy), which became effective on April 20, 2001. The stated purpose of the Policy is "[t]o provide written procedures regarding Lehigh County Prison's suicide prevention program in order to protect inmates from self-harm or death." Reproduced Record at 59a (R.R. ). The Policy is also designed to "provide special housing, increased levels of observation, and medical restraint to those inmates who display self-destructive behavior." *Id.* All inmates are evaluated, and any inmate identified as a potential suicide risk is [*3] further evaluated by a nurse or psychiatrist. If the evaluator determines that the inmate requires an increased level of care, then the inmate can be placed on one of three levels of increased observation: "close observation," "suicide precaution" or "medical restraints." R.R. 60a-61a.

The minimum level of observation is "close observation" status. Close observation includes a periodic check on an inmate's behavior. Observations are documented by the Housing Unit Officer on a Psychiatric Check Report, which is submitted to the Medical Department n2 at the end of each shift. Medical staff review the check reports each shift for any significant changes in behavior.

n2 "Medical Department" refers to Wexford Health Sources, which is the independent medical provider at the Prison. Wexford Health Sources is not a party to this action.

"Suicide precaution" status is the intermediate level of observation under the Policy. An inmate on

suicide precaution is housed in an open-barred cell clothed only in a blanket, and [*4] is periodically checked by a guard. Specifically, the Policy sets the following monitoring and housing requirements for an inmate on suicide precaution status:

a) The Housing Unit Officer shall issue a heavy blanket in good structural condition to the inmate.

b) The Nurse shall place the inmate on Finger Foods/No Utensil status.

c) The Housing Unit Officer shall offer a daily shower to the inmate and directly supervise the inmate showering.

d) The Housing Unit Officer shall monitor the inmate at irregular fifteen-minute intervals (no more than fifteen minutes between checks). The checks are staggered so that there is no predictable pattern for the inmate to use in planning suicide.

e) The Housing Unit Officer shall document suicide checks on the psychiatric check form and submit it to the medical department at the end of each shift.

f) Medical staff will review the check report each shift for any significant changes in behavior.

g) Medical staff will have daily contact with the inmate.

h) In the event of an official visitor (i.e. attorney, parole official) the inmate will be dressed and escorted

to the appropriate visit area and remain under [*5] direct visual observation by the escorting officer.

R.R. 60a.

The Policy's most restrictive level of observation requires physical restraint when ordered by a physician. An inmate who exhibits extreme behavior potentially or actually harmful to himself or to others may be placed in a restraint chair. The use of "medical restraints" is subject to the following conditions in the Policy:

a) The [restraint chair] is the only approved form of medical restraint.

b) Staff supervising the placing of an inmate into the Restraint Chair must be trained in its use.

c) Medical personnel must check the initial application of restraints to ensure circulation is not impaired.

d) The inmate will be dressed in clothing appropriate to temperature unless otherwise specified by the mental health order.

e) Medical staff shall make an assessment every two hours of the inmate's behavior, position, restraints, and health care needs (food, water, elimination and cleanliness) and ensure the needs are met.

f) The Housing Unit Officer shall monitor the inmate at irregular fifteen-minute intervals (no more than fifteen minutes between checks).

g) The Housing Unit [*6] Officer shall document medical restraint checks on a Psychiatric Check Report Form and submit them to the Medical Department at the end of each shift.

h) Medical staff will review the check report each shift for any significant changes in behavior.

i) The Housing Unit Officer shall document each time the inmate is released from medical restraints, or the reason for not releasing the restraints.

j) Medical restraint orders shall not exceed 24 hours.

k) Medical restraints shall not be removed without a physician's order with the following exception. The Housing Unit Officer shall remove the restraints every two hours for ten minutes unless the inmate is extremely agitated. The inmate must be monitored continuously when out of medical restraints.

R.R. 61a.

Dale Meisel began working at the Prison in 1989 and became warden in February 2002. He would later testify by deposition that he had no specific recollection of writing the Policy that was in place at the time of Decedent's suicide. Meisel Deposition, August 29, 2005, at 44 (Meisel Depo. ). Meisel acknowledged, however, that as warden he is responsible for promulgating all policies for [*7] the prison, which

are then co-signed by the Director of Corrections for Lehigh County, in this case Edward Sweeney. *Id.* at 50. n3 Meisel is also responsible for training correctional officers and for enforcing all Prison policies.

n3 The Policy at issue in this case was signed by Edward Sweeney on April 20, 2001. Sweeney was not named as a defendant in the Estate's *Section 1983* action.

In their depositions, Meisel and Sweeney acknowledged that the open-barred cell used to house suicidal inmates has points that can be used by a suicidal inmate to hang himself. Nevertheless, they did not believe a solid plastic wall was preferable. The inmate could scratch the wall until it was opaque and difficult to see through. In addition, a solid wall would impede the ability of guards to hear what an inmate was doing. Meisel Depo. 84-85, 114-115; Sweeney Deposition, September 8, 2005, at 54, 101 (Sweeney Depo. ); Supplemental Reproduced Record at 14b-15b; 25b-26b; 35b; 49b (S.R.R. [*8] ).

**Decedent's Incarceration and Suicide**

Decedent's first period of incarceration was from February 2002 until April 2002. Upon his incarceration Decedent was immediately placed on suicide precaution status. Decedent attempted to hang himself with a makeshift rope on February 11, 2002, and remained on suicide precaution status until February 21, 2002, when he was downgraded to close observation status. Decedent was removed from close observation status on February 25, 2002. He was returned to suicide precaution status on March 30,

2002, and remained on that status until he was released from the Prison on April 2, 2002.

Decedent returned to Prison on October 27, 2002, and was placed on suicide precaution status. After he engaged in self-injurious behavior, he was placed in a restraint chair with the authorization of the Medical Department and remained on suicide precaution status. On October 28, 2002, Decedent attempted to hang himself by tying a strip of blanket around his neck and attaching it to the cell bars. He was again placed in a restraint chair. On November 4, 2002, Decedent was transferred to the Mental Health Unit where he remained on suicide precaution status until [*9] November 14, 2002.

On December 4, 2002, Decedent became enraged upon learning he was being switched to a different cell in the Mental Health Unit and began engaging in self-injurious behavior. He was placed in a "suicide precaution cell," specifically Cell 3223, in the Administrative Segregation/Disciplinary Segregation Unit. n4 A cell is designated a "suicide precaution cell" based upon the recommendations of both custody staff and treatment staff; must be subject to the best available sight line from the control booth; and must be an "open bar" cell. Meisel Depo. 71; R.R. 125a. After he was placed in Cell 3223, Decedent attempted to hang himself by tying his underwear to a towel bar. Accordingly, the Medical Department directed officers to remove Decedent's clothing, gave him a blanket and placed him in a restraint chair from 8:45 p.m. to 9:00 p.m. Officers attempted to remove Decedent from the chair between 10:30 p.m. and 10:45 p.m., but Decedent refused and stated that he would harm himself. The Medical Department placed Decedent on suicide precaution status at 11:18 p.m. Dece-

dent was removed from the restraint chair at 12:30 a.m. on December 5, 2002, and a mattress, after first [*10] being examined by an officer, was placed in Cell 3223. Officers checked Decedent every 30 minutes from 12:00 a.m. to 7:30 a.m., and thereafter every 15 minutes until 4:00 p.m. At 4:10 p.m. Decedent was found standing with his back to the cell door and with a piece of bed linen tied around his neck and attached to the cell door. Decedent was transferred to the hospital and pronounced dead at 4:54 p.m.

n4 There are three correctional officers assigned to the Administrative Segregation/Disciplinary Segregation Unit, in contrast to other units of the Prison where only one correctional officer is assigned. One of the three officers is assigned to the control booth and the other two officers are responsible for walking the pod. The correctional officer in the booth is responsible for monitoring an inmate who, pursuant to the Policy, requires observation. All three of the correctional officers are responsible for observing a potentially suicidal inmate. *See* Meisel Depo. 76-77; Sweeney Depo. 66-67. If the officer assigned to the booth cannot observe the inmate, one of the other correctional officers on the pod is required to go to the cell and check on the inmate.

[*11]

**Prior Incidents**

According to Meisel and Sweeney, approximately 6,500 inmates pass through the Prison every year. Meisel Depo. 94; Sweeney Depo. 107. The Estate's evidence confirmed this figure. S.R.R. 172b-173b.

Three inmates have committed suicide since the Prison opened in 1992. Meisel Depo. 32, 42. The first successful suicide was in 1995, when an inmate took his own life by hanging. S.R.R. 159b. Decedent's suicide was the second. The third incident occurred in 2003 or 2004, after Decedent's suicide. Meisel Depo. 42. Additionally, the Estate's evidence showed that between February 7, 2000, and October 28, 2002, there were five suicide attempts, including Decedent's first attempt to hang himself. S.R.R. 159b-169b.

**Procedural History**

The Estate filed a civil action under *42 U.S.C. § 1983* against Meisel and Lehigh County on December 10, 2004, alleging, *inter alia*, that "the policies and practices of the County of Lehigh were the direct and proximate cause of the constitutional harm caused to [Decedent]." Complaint, P12. n5 The Estate sought compensatory damages from Meisel, in his supervisory capacity as Warden, and from Lehigh County under **[*12]** a theory of municipal liability. The Estate also requested that the trial court declare the Policy unlawful and enjoin its continued use. Meisel and Lehigh County moved for summary judgment, which the trial court initially denied on January 3, 2006. Upon reconsideration, the trial court heard oral argument and granted summary judgment in favor of Meisel and Lehigh County on April 26, 2006. The Estate now appeals the trial court's order.

n5 The complaint pled wrongful death and survivor actions under *42 Pa. C.S. §§ 8301-8302*, as well as violations of the *First, Fourth, Fifth, Eighth* and *Fourteenth Amendment to the United States Consti-*

*tution* and *Article I, Section 8 of the Pennsylvania Constitution*. By the time the judgment in favor of Meisel and Lehigh County was entered, only the *Eighth* and *Fourteenth Amendment* claims remained in litigation.

On appeal, n6 the Estate argues that the trial court erred in granting summary judgment to Meisel and Lehigh County. The Estate argues that its evidence, an expert report, [*13] raised a factual question of whether the procedures in effect at the prison were "constitutionally infirm." Estate's Brief at 3. Thus, the question of whether Meisel and Lehigh County responded with "deliberate indifference" to Decedent's vulnerability to suicide must be decided by a jury. The Estate also contends that the trial court impermissibly relied upon oral deposition testimony in granting summary judgment. *Borough of Nanty-Glo v. American Surety Co. of New York, 309 Pa. 236, 163 A. 523 (1932)*. We consider these questions *seriatim*.

n6 In reviewing a trial court's order granting summary judgment, "[a]n appellate court may disturb the order of the trial court only where there has been an error of law or a manifest abuse of discretion. Notwithstanding, the scope of review is plenary and the appellate court shall apply the same standard for summary judgment as the trial court." *Cooper v. Delaware Valley Medical Center, 539 Pa. 620, 632, 654 A.2d 547, 553 (1995)*. Summary judgment may be granted if the pleadings, depositions, answers to interrogatories, and admissions on file, together with the affidavits, if any, show that there is no genuine issue of material fact and that the moving

party is entitled to a judgment as a matter of law. *Pa. R.C.P. No. 1035.2; Limbach Co., LLC v. City of Philadelphia, 905 A.2d 567, 572 (Pa. Cmwlth. 2006).* The record must be viewed in the light most favorable to the opposing party, and all doubts as to the existence of a genuine issue of material fact must be resolved against the moving party. *Id. at 573.* Summary judgment is proper only when the facts are so clear that reasonable minds cannot differ. *Id.*

[*14]

***Eighth Amendment* Prison Standards**

The gravamen of the Estate's action is that Meisel and Lehigh County subjected Decedent to cruel and unusual punishment in violation of the *Eighth Amendment to the United States Constitution*, made applicable to the states by the *Fourteenth Amendment.* n7 *Estelle v. Gamble, 429 U.S. 97, 101, 97 S. Ct. 285, 50 L. Ed. 2d 251 (1976).* The prohibition against cruel and unusual punishment is broad enough to proscribe "deliberate indifference to serious medical needs of prisoners [that] constitutes the 'unnecessary and wanton infliction of pain.'" *Id. at 104* (citation omitted). Accordingly, "deliberate indifference to a prisoner's serious illness or injury states a cause of action under [*42 U.S.C. § ] 1983.*" *Id. at 105.*

n7 The *Eighth Amendment* provides: "Excessive bail shall not be required, nor excessive fines imposed, nor cruel and unusual punishments inflicted." *U.S.Const. amend. VIII.* The *Fourteenth Amendment* provides, in pertinent part: "No State shall make or enforce any law which shall abridge the privileges or

immunities of citizens of the United States; nor shall any State deprive any person of life, liberty, or property, without due process of law; nor deny to any person within its jurisdiction the equal protection of the laws." *U.S. Const. amend. XIV, § 1.*

[*15]

A serious medical need can include a psychiatric one. In *Colburn v. Upper Darby Township, 838 F.2d 663 (3d Cir. 1988) (Colburn I)*, it was held that an inmate's "particular vulnerability to suicide" represents a "serious medical need" as that term was defined in *Estelle.* Subsequently, the Third Circuit articulated a standard for prison suicide cases as follows:

[A] plaintiff in a prison suicide case has the burden of establishing three elements: (1) the detainee had a "particular vulnerability to suicide," (2) the custodial officer or officers knew or should have known of that vulnerability, and (3) those officers "acted with reckless indifference" to the detainee's particular vulnerability.

*Colburn v. Upper Darby Township, 946 F.2d 1017, 1023 (3d Cir. 1991) (Colburn II).* The *Colburn II* court explained that the terms "reckless indifference" and "deliberate indifference" are interchangeable. *Id. at 1024.* It declined to precisely define "deliberate indifference," but noted that "a level of culpability higher than a negligent failure to protect from self-inflicted harm is required and that this requirement

[*16] is relevant to an evaluation of the first two ... elements as well as the third." *Id.*

Three years after *Colburn II* was decided, the United States Supreme Court offered its first articulation of "deliberate indifference" for purposes of its *Eighth Amendment* jurisprudence. In *Farmer v. Brennan, 511 U.S. 825, 114 S. Ct. 1970, 128 L. Ed. 2d 811 (1994)*, n8 the Supreme Court rejected an objective test for deliberate indifference, such as that adopted by the Third Circuit in *Coburn II*. Instead, the Court borrowed the concept of subjective recklessness from criminal law and held that

a prison official cannot be found liable under the *Eighth Amendment* for denying an inmate humane conditions of confinement unless the official *knows of and disregards an excessive risk to inmate health or safety; the official must both be aware of facts from which the inference could be drawn that a substantial risk of serious harm exists, and he must also draw the inference.* ...

*Id. at 837* (emphasis added). n9 The Court explained further that "prison officials who actually knew of a substantial risk to inmate health or safety may be found free from liability [*17] if they responded reasonably to the risk, even if the harm ultimately was not averted." *Id. at 844.*

n8 *Farmer* was not a *Section 1983* action but, rather, a *Bivens*-type suit brought by an inmate in a federal prison against federal prison officials. Nevertheless, it is the last word on what the *Eighth*

*Amendment* requires with respect to prison health and safety. Further, *Farmer* did not concern a prison suicide but, rather, the violent assault of a transsexual inmate by other inmates. It was alleged that the federal prison officials acted with deliberate indifference when they placed a transsexual inmate in the general prison population, thereby failing to protect him from attacks of other inmates.

n9 The Estate contends, and the trial court agreed, that *Farmer* effectively eliminated the objective "should have known" language from the second prong of the *Colburn II* standard. Notably, the Third Circuit continues to evaluate the liability of prison officials in prison suicide cases in accordance with the *Colburn II* standard, including whether the official "knew or should have known" of an inmate's particular vulnerability to suicide. *See, e.g., Woloszyn v. County of Lawrence, 396 F.3d 314 (3d Cir. 2005).* This Court is not bound by the Third Circuit's interpretation of the *Eighth Amendment* but only by our Supreme Court's interpretations and those of the United States Supreme Court. *See Thomas v. City of Philadelphia, 804 A.2d 97, 111 n. 29 (Pa. Cmwlth. 2002).*

**[*18]**

In establishing a subjective test, the Supreme Court drew on precedent holding that the constitutional deprivation had to be obvious and that the prison official must have "a sufficiently culpable state of mind." *Id. at 834.* Further, that state of mind must be "more blameworthy than negligence." *Id. at 835.* In rejecting the objective test for deliberate indifference, the Supreme Court explained as follows:

[A]n official's *failure to alleviate a significant risk that he should have perceived but did not,* while no cause for commendation, cannot under our cases be condemned as the infliction of punishment.

*Id. at 838* (emphasis added). Therefore, an official who is not aware of a substantial risk cannot be held liable under the *Eighth Amendment.* Nevertheless, the Supreme Court allowed that the fact finder might find the existence of subjective knowledge on the part of a prison official if it could be shown that inmates had suffered numerous injuries in the prison. *Id. at 842. See also Beers-Capitol v. Whetzel, 256 F.3d 120, 133 (3d Cir. 2001)* ("[S]ubjective knowledge on the part of the official can be proved by circumstantial [*19] evidence to the effect that the excessive risk was so obvious that the official must have known of the risk.").

**Liability of Meisel**

The Estate did not sue any custodial officer or medical personnel who dealt with Decedent at the Prison. The trial court found that Meisel had no direct involvement with Decedent and, thus, "Meisel did not act with reckless indifference with respect to [D]ecedent's suicidal ideations and attempts to kill himself." Trial Court Opinion at 8. The only question was whether Meisel had liability for his actions as a supervisor, particularly with respect to the adoption of the Policy. The trial court found that Meisel could not be held liable, and we agree.

The gravamen of the Estate's claim is that the Policy, for which Meisel bears at least some responsibility, was "deliberately indifferent" to the Decedent's known vulnerability to suicide and therefore unconstitutional. n10 The Estate argues that Meisel considered nationally accepted suicide prevention standards promulgated by the American Correctional Association (ACA) and the National Commission on Correctional Health Care (NCCHC), n11 but he did not incorporate them into the Policy. The result, **[*20]** the Estate claims, was a Policy deliberately indifferent to the needs of those inmates, including Decedent, with a vulnerability to suicide. The Estate identifies two ways in which the Policy's deviations from the ACA and NCCHC's standards made the Policy constitutionally infirm.

n10 The Estate essentially conceded at oral argument that its case hinges on the constitutionality of the Policy itself.

n11 The Policy specifically references the ACA and NCCHC standards, and Sweeney acknowledged that the standards were considered in formulating the Policy. Sweeney Depo. 44. To support their deliberate indifference claim, Appellants relied on the ACA and NCCHC standards as well as a report authored by their expert, Lindsay M. Hayes, who opined, based on the standards, that the Policy was constitutionally infirm. Hayes is a project director at the National Center on Institutions and Alternatives and a nationally recognized expert in the field of suicide prevention in correctional facilities.

First, the Estate [*21] objects to the Policy because it does not require, or even provide for, "constant observation" of suicidal inmates. By contrast, the NCCHC standards suggest that "[a]n inmate assessed as being a high suicide risk always should be observed on a continuing, uninterrupted basis or transferred to an appropriate health care facility." R.R. 73a. Although constant observation is, and has been, provided to Prison inmates when ordered by medical staff, the Estate rejoins that this is insufficient. The NCCHC standards require constant observation of a suicidal inmate, with or without a medical order. If Decedent had been under constant observation, even by a fellow inmate, the Estate believes he would not have been able to hang himself.

Second, the Estate complains that the Prison's "suicide precaution cells," required under the Policy, are not suicide-resistant because they have open bars and other ligature points, such as towel bars. The NCCHC recommends that a suicidal inmate's cell "should be as nearly suicide-proof as possible (i.e., without protrusions of any kind that would enable the inmate to hang him/herself)." R.R. 73a. The Estate argues that covering the cell bars with a clear [*22] material is a more effective way to make a cell suicide-resistant.

The Estate's reliance on the ACA and NCCHC standards as the baseline against which to measure the constitutionality of the Policy is misplaced. Those standards represent the recommendations of private organizations in the corrections field that provide accreditation services to correctional facilities. They were not intended to be constitutional mandates, nor could they be since they have not been adopted by any governmental entity. The failure of a correc-

tional facility to comply with these standards means only that it will not be accredited by ACA or NCCHC.

Moreover, the United States Supreme Court has held, in the context of a prison conditions case, that correctional standards issued by organizations like ACA and NCCHC, and even by the Department of Justice, may be instructive in certain cases but "do not establish the constitutional minima; rather, they establish goals recommended by the organization in question." *Bell v. Wolfish, 441 U.S. 520, 543 n. 27, 99 S. Ct. 1861, 60 L. Ed. 2d 447 (1979).* Meisel explained, for example, why cells with clear, solid walls, as recommended by the ACA and NCCHC, were not preferable [*23] to the open-barred holding cells in the Prison used to house suicidal inmates. Even if Meisel were wrong in his judgment, this does not demonstrate deliberate indifference but, at most, negligence. Deliberate indifference "describes a state of mind more blameworthy than negligence." *Farmer, 511 U.S. at 835.*

Other cases involving a challenge to the constitutionality of a prison's suicide prevention policy illustrate the Estate's very high burden in this case. For example, in *Litz v. City of Allentown, 896 F. Supp. 1401 (E.D. Pa. 1995),* the plaintiff's ward, Bobby F. Chain, Jr., attempted to commit suicide while in a holding cell at the Allentown Police Department. Department policies required officers to remove prisoners' belts, excess clothing, shoelaces and personal effects. In addition, video cameras were installed in the cells and officers were required to observe prisoners every 30 minutes, or every 15 minutes if the prisoner was suicidal. Despite these measures, Chain attempted to hang himself with his socks and suffered brain damage. Plaintiff initiated a *Section 1983* ac-

tion against the City of Allentown, the Chief of Police and several other [*24] officers in their official capacities. Plaintiff argued, *inter alia*, that certain proposed department policies, which were rejected, would have prevented the incident. These included installing a videotaping system; removing prisoners' socks; removing prisoners' clothing and providing them with paper suits; and installing wire mesh on the bars of cell doors. Based on these omissions, plaintiff claimed that defendants engaged in an unconstitutional custom, practice or policy.

The District Court granted summary judgment in favor of the municipal defendants. In doing so, the court thoroughly reviewed the development of the Third Circuit's legal standard for *Section 1983* liability in prisoner suicide cases, culminating with *Colburn I* and *Colburn II*. The District Court held that in order to state a cognizable claim under *Section 1983*, plaintiff had to show

the policymakers were aware of (1) the risk of suicides in city lockups, and (2) feasible alternatives for preventing them, and that they either (a) deliberately chose not to pursue those alternatives, or (b) acquiesced in a long-standing policy or custom of inaction.

*Id. at 1412* (citing [*25] *Simmons v. City of Philadelphia, 947 F.2d 1042, 1067 (3d Cir. 1991)* (opinion announcing judgment of the court)). n12

n12 The District Court found deliberate indifference in *Simmons v. City of Philadelphia, 728 F.*

*Supp. 352 (E.D. Pa. 1990)*, and its decision was affirmed by the Third Circuit in the above-cited judgment of the court. In *Simmons*, the City of Philadelphia lock-up officers admitted to having no training in suicide prevention, despite the fact that 20 people committed suicide in a five-year period in City lock-ups under circumstances similar to the decedent's. *Id. at 356.* The City failed to implement numerous preventative measures which could have saved the decedent; the officers took no preventative action despite knowing that the decedent was high-risk; and they made no effort to perform any type of resuscitation after he was found hanging in his cell. *Id. at 353-354.*

Applying the foregoing standard, the District Court noted **[*26]** that only three successful suicides and several attempted suicides had occurred in the six years preceding Chain's attempt to hang himself. During that time the municipality had adopted policies requiring the removal of excess clothing and observation of detainees to prevent such incidents. The municipality's actions, in the court's view, did not communicate a message of tacit approval of, or acquiescence in, prisoner suicides. Rather, the policy reflected a reasonable response to the risk of suicide, and went beyond the steps taken in other cases where a similar constitutional challenge to a suicide prevention policy was rejected. *See, e.g., Williams v. Borough of West Chester, 891 F.2d 458 (3d Cir. 1989)* (plaintiff claimed that municipality had violated decedent's rights by failing to require removal of detainees' belts, install visual surveillance equipment, allocate funds for mental health treatment, and train officers in handling at-risk detainees). Accordingly,

the *Litz* court held that the failure of the city to adopt the additional measures identified by plaintiff at most amounted to "mere negligence, which falls short of the threshold for stating a *Section* [*27] *1983* claim." *Litz, 896 F. Supp. at 1413.*

As in *Litz*, the Estate's challenge to the Policy is not based upon evidence tending to show "a level of culpability higher than a negligent failure to protect [Decedent] from self-inflicted harm." *Colburn II, 946 F.2d at 1024.* The Estate had to demonstrate that Meisel had subjective knowledge of a substantial risk of serious harm to suicidal inmates and consciously chose to disregard that risk. The Estate had to show what the Supreme Court has characterized as a "culpable state of mind" that is "more blameworthy than negligence." *Farmer, 511 U.S. at 834, 835.* The Third Circuit has characterized this state of mind as "scienter-like evidence of indifference on the part of a particular policymaker or policymakers." *Simmons, 947 F.2d at 1060-1061.* n13 The Estate simply failed to demonstrate this requisite culpable state of mind on the part of Meisel.

n13 Although *Simmons* was a plurality decision, the Third Circuit cited the "scienter-like evidence" language with approval in *Parkway Garage, Inc. v. City of Philadelphia, 5 F.3d 685, 692 (3d Cir. 1993), abrogated on other grounds, United Artists Theatre Circuit, Inc. v. Township of Warrington, 316 F.3d 392 (3d Cir. 2003).*

[*28]

Significant to the trial court's analysis, and our own, is the fact that there was only one inmate sui-

cide at the Prison before Decedent's, and that incident occurred in 1995, seven years before Decedent took his own life. Moreover, the Estate's own evidence showed that there were only five suicide attempts between 2000 and 2002, including Decedent's first attempt. There was certainly no pattern of such incidents that showed that there was an obvious risk which the Policy did not address. Stated otherwise, there was no circumstantial evidence presented by the Estate that would have allowed the trial court to find that there was a substantial risk of suicide created by the Policy that was known to Meisel. n14 *Farmer, 511 U.S. at 842, Beers-Capitol, 256 F.3d at 133.* To the contrary, given the large number of persons that passed through the Prison during Meisel's tenure, in excess of 50,000, and the infrequent suicides, three between 1989 and 2003, the Policy appeared to be effective in preventing suicides by inmates.

n14 Actual knowledge could be demonstrated by evidence showing that a substantial risk of inmate suicides was "longstanding, pervasive, well-documented, or expressly noted by prison officials in the past, and the circumstances suggest that the defendant-official being sued had been exposed to information concerning the risk...then such evidence could be sufficient to permit a trier of fact to find that the defendant-official had actual knowledge of the risk." *Farmer, 511 U.S. at 842-843.*

**[*29]**

The final piece of the Estate's claim against Meisel is the assertion that the Policy, ineffective as it was, was not properly implemented. The Estate

contends that the suicide precaution cell in which Decedent was last housed, Cell 3223, in addition to not being suicide-resistant, was not clearly observable from the guard control booth, as required by the Policy. The Estate asserts that the slighting between the control booth and Cell 3223 was partially obstructed by an open staircase. A completely unobstructed slighting between the booth and Cell 3223 would have allowed for better observation of Decedent and prevented him from hanging himself.

However, the Estate failed to produce any evidence that Meisel knew that Cell 3223 was unsafe and continued to use it as a suicide prevention cell. In the absence of this knowledge, Meisel cannot be found deliberately indifferent, even if we accept the Estate's premise that Cell 3223 was an inappropriate cell in which to place Decedent.

This is also the flaw in the Estate's claim that Decedent should have been placed under constant observation. The Estate presented no evidence that had the medical staff directed more observation of Decedent, [*30] it would not have been provided. As noted by the trial court, suicide is a mental health issue, and the custodial officers relied upon the advice of mental health professionals in dealing with Decedent. This is not deliberate indifference by anyone at the Prison, least of all by Meisel.

This is undeniably a tragic case. A single suicide in any correctional facility is one too many. Nevertheless, as the Third Circuit admonished, "we cannot place . . . custodial officers and employees 'in the position of guaranteeing that inmates will not commit suicide.'" *Colburn II, 946 F.2d at 1030-1031* (quoting *Colburn I, 838 F.2d at 669*). At every stage of Dece-

dent's incarceration, the officers supervised by Meisel made a concerted effort to keep Decedent safe and to prevent him from harming himself. Decedent was evaluated by medical staff and placed on increased levels of observation as warranted, including physical restraint. He was frequently observed by Prison officials in accordance with the Policy. n15 The Estate simply presented no evidence that Meisel consciously made decisions with respect to Decedent individually, or suicidal inmates generally, to place [*31] him and other suicidal inmates at risk.

n15 Based upon these uncontradicted facts, the trial court observed as follows:

[D]ecedent's placement on suicide watch by the medical staff and the [D]ecedent's ultimate placement in Cell 3223 were reasonable under the circumstances |. The record reflects that Defendant Dale Meisel, as a supervisor, acted reasonably with respect to the [D]ecedent and his risk of suicide, and [D]ecedent's injury does not bear a close causal relationship to Defendant Dale Meisel's alleged failure to respond adequately.

Trial Court Opinion at 15-16. The Estate contends that it was for the jury, not the trial court, to make these findings of reasonableness. The Estate's argument here is flawed.

—First, the holding of the trial court did not turn on the question of whether Meisel responded reasonably to Decedent's medical needs but whether Meisel had subjective knowledge of Decedent's particular situa-

tion. Because Meisel did not have actual knowledge about Decedent, the inquiry does not need to go to the next step directed by *Farmer, i.e.*, whether the prison official acted reasonably. *Farmer, 511 U.S. at 844.* Accordingly, the trial court's above-cited observations are not central to the holding and, thus, are *dicta*.

Second, we disagree that the conclusion of whether a prison official with actual knowledge acted reasonably, assuming it were dispositive in this case, is a factual question. It is for the courts to determine, under *Farmer*, whether particular conduct is so unreasonable as to constitute the infliction of cruel and unusual punishment.

We agree with Meisel and Lehigh County that the Estate's argument twists the deliberate indifference inquiry into a question of whether a prison policy or practice was reasonable. That is not what *Farmer* teaches.

[*32]

**Lehigh County Liability**

*Section 1983* provides a vehicle by which a citizen may seek redress from a person who, acting under color of state law, deprives an individual of rights, privileges or immunities secured by the United States Constitution. *42 U.S.C. § 1983.* A municipality is a "person" that can be sued directly under *Section 1983* and held liable, in some circumstances. *Monell v. Dep't of Soc. Servs., 436 U.S. 658, 690, 98 S. Ct. 2018, 56 L. Ed. 2d 611 (1978).* Of course, municipal officials acting in their official capacity are also considered "persons" under *Section 1983. Id. at 690, n. 55.* A municipality cannot, however, be held liable

under *Section 1983* on a *respondeat superior* theory. *Id. at 691.* Rather, liability will be imposed when the municipality implements an official policy that is either unconstitutional on its face or is the "moving force" behind the constitutional tort of one of its employees. *Id. at 694; Polk County v. Dodson, 454 U.S. 312, 326, 102 S. Ct. 445, 70 L. Ed. 2d 509 (1981).* n16

n16 A concededly valid official policy may be deemed the "moving force" behind a constitutional tort when it is "unconstitutionally applied by a municipal employee." *City of Canton, Ohio v. Harris, 489 U.S. 378, 387, 109 S. Ct. 1197, 103 L. Ed. 2d 412 (1989)* (wherein police officers did not summon medical assistance for plaintiff, who fell down several times and became incoherent while being processed at the police station for a speeding violation). Municipal liability under *Section 1983* will lie if the municipality's failure to adequately train its employees results in the constitutional deprivation, *and* the "failure to train" reflects deliberate indifference to the constitutional rights of its inhabitants. *Id. at 392.* The Estate does not assert a "failure to train" theory of liability, opting instead to challenge the Policy itself as unconstitutional.

[*33]

The trial court held that because the Estate failed to show a constitutional violation by a municipal actor, Meisel, its claim against Lehigh County failed as a matter of law. We agree.

The United States Supreme Court has held that *Monell* does not authorize

the award of damages against a municipal corporation based on the actions of one of its officers when in fact the jury has concluded that the officer inflicted no constitutional harm. If a person has suffered no constitutional injury at the hands of the individual police officer, the fact that the departmental regulations might have *authorized* the use of constitutionally excessive force is quite beside the point.

*City of Los Angeles v. Heller, 475 U.S. 796, 799, 106 S. Ct. 1571, 89 L. Ed. 2d 806 (1986)* (emphasis original). In *Trigalet v. City of Tulsa, Oklahoma, 239 F.3d 1150 (10th Cir. 2001)*, the Court of Appeals held, consistent with nearly every other Court of Appeals, that a municipality cannot be held liable in a *Section 1983* action in the absence of a predicate unconstitutional act by the municipality's employee. Even if the municipality's actions are arbitrary or even "conscience **[*34]** shocking, in a constitutional sense" the municipality cannot be held liable under *Section 1983. Id. at 1151.* This is because a claim of "inadequate training [or] supervision . . . under *§ 1983* cannot be made out against a supervisory authority absent a finding of a constitutional violation by the person supervised." *Id. at 1154* (quoting *Webber v. Mefford, 43 F.3d 1340, 1344-45 (10th Cir. 1994)).*

This Court has expressly adopted the *Trigalet* analysis. *Thomas v. City of Philadelphia, 804 A.2d 97, 112 (Pa. Cmwlth. 2002)* ("We hold, therefore, that in the absence of an underlying unconstitutional action by employees of the City . . ., we will not consider the question of whether the City [has liability] . . ."); *Robbins v. Cumberland County Children and*

nounced by our Supreme Court in *Borough of Nanty-Glo v. American Surety Co. of New York, 309 Pa. 236, 163 A. 523 (1932).* The so-called *Nanty-Glo* rule provides that a court may not summarily enter a judgment based upon oral testimony since the credibility of such testimony is within the province of the jury. The Estate argues that the trial court erred by relying upon Meisel's deposition testimony that Prison officials will provide for constant observation of a suicidal inmate when directed to do so by medical staff. The Estate also makes a vague assertion that the trial court erroneously considered Meisel's and Sweeney's testimony that "various alternatives were or were not reasonable or feasible to support Summary Judgment." Appellants' Brief at 24.

The *Nanty-Glo* rule is not applicable to every summary judgment proceeding. *Kirby v. Kirby, 455 Pa. Super. 96, 687 A.2d 385, 388 (Pa. Super. 1997).* Rather, our appellate courts follow a three-step analysis to determine whether the *Nanty-Glo* [*37] rule will preclude a grant of summary judgment:

Initially, it must be determined whether the plaintiff has alleged facts sufficient to establish a prima facie case. If so, the second step is to determine whether there is any discrepancy as to any facts material to the case. Finally, it must be determined whether, in granting summary judgment, the trial court has usurped improperly the role of the jury by resolving any material issues of fact.

*Id. at 388, cited with approval in Azar v. Ferrari, 898 A.2d 55, 61 n.9 (Pa. Cmwlth. 2006).*

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*Id. at 388, cited with approval in Azar v. Ferrari, 898 A.2d 55, 61 n.9 (Pa. Cmwlth. 2006).*

Applying the foregoing test, we find that the *Nanty-Glo* rule is not applicable in this case. While it may be true that the trial court referred to deposition testimony from Meisel, Sweeney and other Prison officials regarding the Prison's policies and practices, that testimony was not dispositive or, in the end, even material to the judgment. As explained at length above, the Estate failed to adduce facts sufficient to establish that Meisel and Lehigh County acted with *deliberate indifference* toward Decedent's known vulnerability to suicide. Therefore, under the first prong of *Kirby*, the Estate failed **[*38]** to establish a *prima facie* case under *42 U.S.C. § 1983*.

**Conclusion**

For the foregoing reasons, we affirm the order of the trial court granting summary judgment in favor of the County of Lehigh and Dale Meisel. n18

n18 In its brief and reply brief to this Court, the Estate argues that the trial court erred by failing to consider whether Meisel and Lehigh County could be held liable under a "state-created danger" theory. We note that this theory of liability is not set forth in the complaint. Assuming, *arguendo*, that the Estate raised and preserved a state-created danger claim, it would not be entitled to relief under that doctrine. In *Robbins v. Cumberland County Children and Youth Services, 802 A.2d 1239 (Pa. Cmwlth. 2002)*, this Court adopted the standard followed by the Third Circuit for liability under the state-created danger theory in *Section 1983* actions. That standard requires that:

(1) the harm ultimately caused was foreseeable and fairly direct; (2) *the State actor acted in willful disregard for the safety of the plaintiff;* (3) there existed some relationship between the State and the plaintiff; [and] (4) the State actors used their authority to create an opportunity that otherwise would not have existed for the third party's crime to occur.

*Id. at 1247 n.8* (citing *Kneipp v. Tedder, 95 F.3d 1199, 1208 (3d Cir. 1996))* (emphasis added). In *Kneipp* the Third Circuit equated "willful disregard" with "deliberate indifference." *Id. at 1208 n. 21.* In the present case, regardless of the theory advanced, the Estate failed to adduce evidence sufficient to demonstrate that the Policy or the actions of Meisel and Lehigh County were deliberately indifferent to Decedent's vulnerability to suicide. Therefore, the Estate's state-created danger theory of liability would have failed as a matter of law.

**[*39]**

MARY HANNAH LEAVITT, Judge

**ORDER**

AND NOW, this 3rd day of May, 2007, the order of the Court of Common Pleas of Lehigh County in the above-captioned matter, entered April 26, 2006, is hereby AFFIRMED.

MARY HANNAH LEAVITT, Judge

**IN THE COURT OF COMMON PLEAS OF LEHIGH COUNTY, PENNSYLVANIA CIVIL DIVISION**

RUTH AROCHO, AS ADMINISTRATRIX OF THE ESTATE OF ENRIQUE RENE VERAS AND WADAYS VERAS AND RUTH AROCHO AS PARENT AND GUARDIAN OF CRYSTAL VERAS AND YASHERA VERAS,
Plaintiffs

vs.

COUNTY OF LEHIGH AND DALE MEISEL,
Defendants

No. 2003-C-3235

* * * * * * * *

APPEARANCES:
DAVID L. DERATZIAN, ESQUIRE,
On behalf of the Plaintiffs
RUDOLPH ZIEGER, ESQUIRE,
THOMAS M. CAFFREY, ESQUIRE,
On behalf of the Defendants

* * * * * * * *

**OPINION**
LAWRENCE J. BRENNER, J.

On or about December 8, 2003, the Plaintiffs, Ruth Arocho, as the Administratrix of the decedent's estate and as the mother of the decedent's minor children, Crystal Veras and Yashera Veras, and Wadays Veras, an adult child of the decedent,

instituted the within action by filing a Summons. Thereafter, on or about December 10, 2004, the Plaintiffs filed a Complaint. In the Complaint, as amended, the Plaintiffs allege that on or about December 5, 2002, due to a significant history of mental illness, the decedent, Enrique Rene Veras, was placed on suicide watch in Lehigh County Prison. While on constant video surveillance, the decedent fashioned a noose from his bedding and hanged himself in his cell. The Plaintiffs seek redress against the Defendants under 42 U.S.C.A. § 1983, alleging that the Defendants violated the decedent's rights under the United States Constitution when the decedent committed suicide in Lehigh County Prison. Specifically, in the Complaint, the Plaintiffs seek to impose liability upon Defendant Dale Meisel, in his supervisory capacity as the Warden of Lehigh County Prison, under 42 U.S.C.A. § 1983. Further, the Plaintiffs seek to impose municipal liability upon Defendant County of Lehigh under 42 U.S.C.A. § 1983 as a result of Lehigh County Prison's Suicide Prevention Policy, which, according to the Plaintiffs, is an unconstitutional policy that caused the decedent's death.

Presently before this Court is the Motion for Summary Judgment of the Defendants. In the Motion for Summary Judgment, the Defendants argue that they were not "deliberately indifferent" to the decedent's risk of suicide. Consequently, the Defendants believe that they are entitled to Summary Judgment. Plaintiffs responded to this Motion for Summary Judgment on December 14, 2005. Oral argument was conducted on the within matter on January 3, 2006. On the same date, this

Court entered an Order denying the Motion for Summary Judgment. On March 3, 2006, the Defendants filed a Motion to Reconsider this interlocutory Order. *Buehl v. Horn*, 728 A.2d 973 (Pa. Cmwlth. 1999); *Key Automotive Equipment Specialists, Inc. v. Abernethy*, 431 Pa. Super. 358, 362, 636 A.2d 1126, 1128 (1994); *Hutchinson v. Luddy*, 417 Pa. Super. 93, 108, 611 A.2d 1280, 1288 (1992); *Cf.* 42 Pa. C.S.A. § 5505. Said Motion to Reconsider was granted by this Court. Then, oral re-argument was conducted on April 17, 2006. Initially we note that summary judgment is properly granted where pleadings, depositions, answers to interrogatories and admissions on file, together with affidavits, if any, show that there is no genuine issue of material fact and that the moving party is entitled to judgment as a matter of law. *Merriweather v. Philadelphia Newspapers, Inc.*, 453 Pa. Super. 464, 471, 684 A.2d 137, 140 (1996), *allocatur denied*, 548 Pa. 628, 693 A.2d 967 (1997); *Coleman v. Coleman*, 444 Pa. Super. 196, 199, 663 A.2d 741, 742-743, *appeal denied*, 543 Pa. 722, 673 A.2d 330 (1995). Moreover, when considering a motion for summary judgment, the Court must examine the record in the light most favorable to the nonmoving party, accepting as true all well pleaded facts and all inferences to be drawn therefrom. *Electronic Lab. Supply Co. v. Cullen*, 712 A.2d 304 (Pa. Super. 1998); *Coleman*, 444 Pa. Super. at 199, 663 A.2d at 742-743.

Furthermore, 42 U.S.C.A. § 1983 provides a remedy against any person who, acting under color of state law, deprives another of rights, privileges, or immunities secured by the Constitution or the law of the United States. 42 U.S.C.A. §1983. This

statute is not, however, a source of substantive rights, but instead, merely provides "a method for vindicating federal rights elsewhere conferred." *Graham v. Connor*, 490 U.S. 386 (1989). The Eighth Amendment applicable to the states under the Fourteenth Amendment, prohibits the cruel and unusual punishment of prisoners, thereby entitling them to medical attention for serious health needs. *Dimitris v. Lancaster County Prison Bd*, 2002 WL 32348283 (E.D. Pa. 2002). 42 U.S.C.A. § 1983 allows recovery for constitutional violations when a prisoner commits suicide after receiving inadequate attention based on his mental health condition. Id. at 5.

*DEFENDANT DALE MEISEL:*

This Court recognizes that in *Colburn v. Upper Darby Township*, 946 F.2d 1017, 1023-1024 (3rd Cir. 1991), the Third Circuit stated that:

> [A] plaintiff in a prison suicide case has the burden of establishing . . . (1) the detainee had a "particular vulnerability to suicide,"[1] (2) the custodial officer or officers knew or should have known of that vulnerability,[2] and (3) those officers "acted with reckless indifference" to

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[1] In *Colburn v. Upper Darby Township*, 838 F.2d 663 (3rd Cir. 1988), the Third Circuit "established the standard for liability to be applied in this circuit in prison suicide cases." *Colburn*, 946 F.2d at 1023.

[2] *Farmer v. Brennan*, 511 U.S. 825, 836, 114 S.Ct. 1970, 1978 (1994) dispensed with the "should have known" in the second prong.

> the detainee's particular vulnerability.[3]

*Colburn*, 946 F.2d at 1023-1024. Of note, the Third Circuit has used the concept of "reckless indifference" and the concept of "deliberate indifference" interchangeably. *See Colburn*, 946 F.2d at 1024. The United States Supreme Court added that "[w]ith deliberate indifference lying . . . between . . . negligence . . . and purpose or knowledge . . . [i]t is fair to say that acting or failing to act with deliberate indifference to a substantial risk of serious harm to a prisoner is the equivalent of recklessly disregarding that risk." *Farmer v. Brennan*, 511 U.S. 825, 836, 114 S.Ct. 1970, 1978 (1994). Noting that "recklessly" is not self-defining, the United States Supreme Court defined "deliberate indifference":

> We reject . . . an objective test. . . . We hold instead that a prison official cannot be found liable under the Eighth Amendment for denying an inmate humane conditions of confinement unless the *official knows of and disregards an excessive risk to inmate health or safety; the official must both be aware of facts from which the inference could be drawn that a substantial risk of serious harm exists, and he must also draw the*

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[3] At the time of oral argument, the Defendants conceded that prongs (1) and (2) have been satisfied. The conflict revolves around prong number (3).

> *inference*. . . an official's failure to alleviate a significant risk that he should have perceived but did not, while no cause for commendation, cannot under our cases be condemned as the infliction of punishment.

*Farmer*, 511 U.S. at 838-839, 114 S.Ct. at 1979 (emphasis supplied). The *Farmer* case applies to inmate suicide cases.

In the instant case, the record plainly reveals that in February of 2002 the decedent was incarcerated and immediately placed on "suicide precaution" status. On February 11, 2002, the decedent tied a makeshift rope around his neck and tied it to the bars in a suicide attempt. The correctional officers cut the noose and thwarted the suicide attempt. The decedent remained on suicide precaution status until February 21, 2002, when he was downgraded to "close observation" status. The decedent was removed from "close observation" status on February 25, 2002. The decedent was returned to "suicide precaution" status on March 30, 2002 and remained on this status until he was released from Lehigh County Prison on April 2, 2002.

The decedent returned to Lehigh County Prison on October 27, 2002, at which time he was placed on "suicide precaution" status. After he engaged in selfinjurious behavior, he was placed in a restraint chair with the authorization of the medical department and remained on "suicide precaution" status. Then, on October 28, 2002, the decedent again attempted suicide by tying a strip of blanket around his neck and attaching it to the cell bars.

Correctional officers again thwarted the suicide attempt by the decedent and the decedent was placed in a restraint chair. On November 4, 2002, the decedent was transferred to the Mental Health Unit and remained on "suicide precaution" status. The decedent was removed from "suicide precaution" status on November 14, 2002.

Subsequently, on December 4, 2002, the decedent became enraged upon being informed that he was being switched to a different cell in the Mental Health Unit and the decedent began to engage in self-injurious behavior. Consequently, the decedent was placed in a "suicide precaution cell", specifically Cell 3223 that is located in the Administrative Segregation/Disciplinary Segregation Unit.[4] It should be noted that in order for a cell to be used as a "suicide precaution cell," it must be subject to the best sight line available from the control booth. Furthermore, a "suicide precaution cell" must also be an open bar cell. A cell is designated a "suicide

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[4] In the Administrative Segregation/Disciplinary Segregation Unit, there are three (3) correctional officers assigned (except in the evening), in contrast to other units of Lehigh County Prison where only one (1) correctional officer is assigned. Of the three (3) correctional officers assigned to this Unit, one (1) of the correctional officers is assigned to the booth and the other two (2) correctional officers are assigned to walk the pod. The correctional officer in the booth is responsible for monitoring an inmate who, pursuant to the Suicide Prevention Policy, requires observation. However, all of the correctional officers in the Administrative Segregation/Disciplinary Segregation Unit are responsible for observing a potentially suicidal inmate, and if the correctional officer in the booth cannot observe the inmate from the control booth, one (1) of the other correctional officers on the pod is required to go to the cell in order to check on the inmate.

precaution cell" based upon the recommendations of both the custody staff and the treatment staff. Indeed, one of Lehigh County Prison's psychiatrists conducts an ongoing evaluation of the cells used by Lehigh County Prison as "suicide precaution cells" and reviews whether the cells have direct access to the officers and are in the visual field of the officers most of the time to make sure that there is nothing that the prisoners can hang themselves with or hang onto. The "suicide precaution cell," Cell 3223, was thoroughly searched by four (4) different correctional officers for any objects that would allow the decedent to harm himself prior to the decedent's placement.[5]

Immediately after being placed in Cell 3223, the decedent again acted out, including an attempt to hang himself by tying his underwear around his neck and to the towel bar in the cell. As a result, the decedent, upon authorization from the medical department, was placed in a restraint chair between 8:45 P.M. and 9:00 P.M. The decedent was given a blanket and was stripped naked. Between 10:30 P.M. and 10:45 P.M., correctional officers attempted to remove the decedent from the restraint chair, but the decedent refused to leave the restraint chair, stating that he would harm himself if he were removed. The medical

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[5] Although Defendant Dale Meisel acknowledges that Cell 3223 does not comply with National Commission on Correctional Health Care Standards because it has fold down hooks, Cell 3223 is an open barred grill and is subject to a good sight line from the control booth. Therefore, Defendant Dale Meisel testified that he believes that Cell 3223 was and continues to be an appropriate suicide precaution cell.

department placed the decedent on "suicide precaution" status at 11:18 P.M. The decedent was removed from the restraint chair at 12:30 A.M. on December 5, 2002. On the morning of December 5, 2002, the decedent was given a mattress in his cell. The mattress was checked by the correction officer. Moreover, the decedent was checked every thirty (30) minutes from midnight through 7:30 A.M. on December 5, 2002, and thereafter every fifteen (15) minutes through 4:00 P.M. On December 5, 2002 at approximately 4:10 P.M. the decedent was found in Cell 3223 standing with his back to the cell door with a ligature around his neck and tied to the cell door. The ligature was characterized as bed linen or a sheet. The correctional officers immediately cut the ligature and summoned medical attention. The decedent was transferred to the hospital where he was pronounced dead at 4:54 P.M.

Based on the record in this case, Defendant Dale Meisel, the Warden of Lehigh County Prison, did not have any direct involvement with respect to the decedent's suicide. Consequently, the Plaintiffs have failed to sustain their burden of establishing the aforementioned three (3) elements as outlined in the *Colburn* case to demonstrate that Defendant Dale Meisel would bear liability for any direct action. In particular, Defendant Dale Meisel did not act with reckless indifference with respect to the decedent's suicidal ideations and attempts to kill himself.

Furthermore, Defendant Dale Meisel bears no liability for his actions as a supervisor.[6] The Third Circuit has applied the deliberate indifference standard to supervisors:

> [B]ased on . . . *City of Canton v. Harris*, 489 U.S. 378, 109 S.Ct. 1197 . . . (1989) . . . to hold a supervisor liable because his policies or practices led to an Eighth Amendment violation, the plaintiff must identify a specific policy or practice that the supervisor failed to employ and show that: (1) the existing policy or practice created an unreasonable risk of the Eighth Amendment injury; (2) the supervisor was aware that the unreasonable risk was created; (3) the supervisor was indifferent to that risk; and (4) the injury resulted from the policy or practice. *See Sample* [*v. Diecks*], 885 F.2d [1099] at 1118 [(3d Cir. 1989)].
>
> . . . one way . . . a plaintiff can make out a supervisor liability claim is by showing that "*the supervisory official failed to respond appropriately in the face of an awareness of a pattern of such injuries.*" *Id.* But that is not the

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[6] As the Warden, Defendant Dale Meisel is responsible for making formal Lehigh County Prison policy which must be co-signed by Edward Sweeney, the Director of Corrections. Defendant Dale Meisel is responsible for the training of the correctional officers and enforcing Lehigh County Prison policies through the chain of command.

> only way to make out such a claim, as "*there are situations in which the risk of constitutionally cognizable harm is so great and so obvious that the risk and the failure of supervisory officials to respond will alone support findings of the existence of an unreasonable risk, of knowledge of that unreasonable risk, and of indifference to it.*" *Id.*
>
> . . . seeking to hold supervisors liable for their deficient policies, *Sample*'s four-part test provides the analytical structure for determining whether the policymakers exhibited deliberate indifference to the plaintiffs' risk of injury, it being simply the deliberate indifference test applied to the specific situation of a policymaker.

*Beers-Capitol v. Whetzel*, 256 F.3d 120, 134-135 (3d Cir. 2001) (emphasis supplied). The *Beers-Capitol* decision noted that "nothing in the *Sample* opinion that we rely on here conflicts with *Farmer*. Id. at 134 n. 7. Further, *Sample* stated:

> The [*Canton*] Court went on to caution . . . that "for liability to attach . . . the identified deficiency in a city's training program must be closely related to the ultimate injury."
>
> * * *
>
> Although the issue here is one of individual liability rather than of the liability of a political subdivision, we

> are confident that . . . the standard of individual liability for supervisory public officials will be found to be no less stringent than the standard of liability for the public entities they serve.
>
> * * *
>
> Under . . . *Canton* it is not enough . . . to argue that the constitutionally cognizable injury would have occurred if the superior had done more than he or she did. The district court must insist that *Sample* identify specifically what it is that Robinson failed to do that evidences his deliberate indifference. Only in the context of a specific defalcation on the part of the supervisory official can the court assess whether the official's conduct evidences deliberate indifference and whether there is a close causal relationship between the "identified deficiency" and the "ultimate injury." Normally, an unreasonable risk in a supervisor liability case will be shown by evidence that such harm has in fact occurred on numerous occasions.

*Sample*, 885 F.2d at 1117-1118. Additionally, *Farmer* rejected *Canton*'s definition of "obvious" in prison settings:

> *Canton*'s objective standard, however, is not an appropriate test for determining the liability of prison officials under the Eighth Amendment

> as interpreted in our cases. . . . [w]e cannot accept petitioner's argument that *Canton* compels the conclusion here that a prison official who was unaware of a substantial risk of harm to an inmate may nevertheless be held liable under the Eighth Amendment if the risk was obvious and a reasonable prison official would have noticed it.

*Farmer*, 511 U.S. at 841-842, 114 S.Ct. at 1981. However, the Court added the following:

> [A]n Eighth Amendment claimant need not show that a prison official acted or failed to act believing that harm actually would befall an inmate; it is enough that the official acted or failed to act despite his knowledge of a substantial risk of serious harm. . . . Whether a prison official had the requisite knowledge of a substantial risk is a question of fact subject to demonstration in the usual ways . . . , and a fact finder may conclude that a prison official knew of a substantial risk from the very fact that the risk was obvious.

*Id.* at 842-843, 114 S.Ct. at 1981-1982. *Beers-Capitol*, an Eighth Amendment case where Liggett was sued as a supervisor, recognized Farmer's definition of "obvious":

> The deliberate indifference standard as set out in *Farmer* is a high one,

> however – requiring actual knowledge or awareness on the part of the defendant . . . whether the above policies and practices created a risk of harm . . . that was 'so great and so obvious' that [supervisor] Liggett must have known of the excessive risk but was indifferent to it.

*Beers-Capitol*, 256 F.3d at 125, 135-137. Further, prison officials who actually know of a substantial risk to inmate health or safety may be found free from liability if they respond reasonably to the risk, even if the harm ultimately was not averted. *Farmer*, 511 U.S. at 844, 114 S.Ct. at 1982-1983.

Moreover, the existence of an obvious risk can sometimes be inferred from a long-standing pattern or practice that would have alerted a defendant to a risk of maintaining a course of action. In the within matter, there is no pattern of relevant injury. Indeed, the record reflects that approximately 6,500 inmates pass through Lehigh County Prison each year and from 1993 until December of 2002, Lehigh County Prison housed approximately 50,000 inmates. Also, Lehigh County Prison records indicate that from February of 1989, when Defendant Dale Meisel's tenure in the department of correction started, until December 4, 2002, there was only one (1) inmate suicide which occurred in 1995. In fact, Defendant Dale Meisel was only aware of three (3) inmates suicides: one (1) in 1995, the decedent's suicide and one (1) after the decedent's suicide. Thus, Defendant Dale Meisel

could not be aware of any pattern of suicides, as none existed.[7]

Furthermore, Defendant Dale Meisel, as a supervisor, acted reasonably with respect to the decedent and his risk of suicide, and decedent's injury does not bear a close causal relationship to Defendant Dale Meisel's alleged failure to respond adequately. The National Commission on Correctional Heath Care's Suicide Prevention Standard J-51 stated, in relevant part to decedent's suicide:

Key components of a suicide prevention program include the following:

> 3. Assessment. This should be conducted by a qualified mental health professional, who designates the inmate's level of suicide risk.
>
> 4. Monitoring. The plan should specify the facility's procedures for monitoring an inmate who has been identified as potentially suicidal. Regular documented supervision should be maintained. . . .
>
> 5. Housing. A suicidal inmate should not be housed or left alone.

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[7] Further, it should be noted that there were only five (5) suicide attempts, including the decedent's suicide attempt that resulted in hospitalization, from 2000 through 2002 in the Lehigh County Prison.

> An appropriate level of observation must be maintained. If a sufficiently large staff is not available that constant supervision can be provided when needed, the inmate should not be isolated. Rather, s/he should be housed with another resident or in a dormitory and checked every 10-15 minutes. An inmate assessed as being a high suicide risk always should be observed on a continuing, uninterrupted basis or transferred to an appropriate health care facility. The room should be as nearly suicide-proof as possible (i.e., without protrusions of any kind that would enable the inmate to hang him/herself).
>
> 6. Referral. The plan should specify the procedures for referring potential suicidal inmates and attempted suicides to mental health care providers or facilities.

*See* The National Commission on Correctional Heath Care's Suicide Prevention Standard J-51.

At issue in this case is Lehigh County Prison's Suicide Prevention Policy which is the Lehigh County Prison Policy 5.5, Suicide Prevention, effective April 20, 2001.[8] The stated purpose of the

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[8] This Suicide Prevention Policy is supplemented by Lehigh County Prison's practices, policies and procedures. Also, at the time of the decedent's death the Suicide Prevention Policy was

Suicide Prevention Policy is "[t]o provide written procedures regarding Lehigh County Prison's Suicide Prevention Program in order to protect inmates from self-harm or death." The Suicide Prevention Policy further provides that "[i]t is the policy of Lehigh County Prison to provide special housing, increased levels of observations, and medical restraint to those inmates who display self-destructive behavior."

The Suicide Prevention Policy initially provides for the identification and referral of potentially suicidal inmates. All inmates are initially evaluated by a registered or licensed practical nurse for suicide risk. Inmates who express suicidal ideation or behaviors to a staff member are immediately referred to the medical staff for evaluation. Specifically, inmates identified as potentially suicidal are evaluated by a nurse or psychiatrist. If the evaluator determines that the inmate requires an increased level of attention, he or she may order close observations, suicide precautions or medical restraint.[9] The evaluator's determination is communicated to Lehigh County Prison staff both verbally and in writing. Under "close observations," there is a specified time interval for checking on an inmate's behavior. Lehigh County Prison staff is required to document what is observed and this

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supplemented by the policy and procedures adopted by Wexford Health Sources, the independent medical provider at Lehigh County Prison. Wexford Health Sources' policies provide for medical autonomy by its medical staff.

[9] The Suicide Prevention Policy provides for incremental levels of observation and care.

information is submitted to the medical department for further evaluation.

The next level of observation and care under the Suicide Prevention Policy is "suicide precaution," which involves placing the inmate in an open barred cell for direct observation, removing the inmate's clothing and all other cell contents. This level of observation and care requires the following:

> 1. The housing unit officer shall issue a heavy blanket in good structural condition to the inmate.
>
> 2. The nurse shall place the inmate on finger foods/no utensil status.
>
> 3. The housing unit officer shall offer a daily shower to the inmate and directly supervise the inmate showering.
>
> 4. The housing unit officer shall monitor the inmate at irregular fifteen-minute intervals (no more than fifteen minutes between checks). The checks are staggered so that there is no predictable pattern for the inmate to use in planning suicide.[10]

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[10] More frequent monitoring of the inmate is permitted and the Lehigh County Prison psychiatrist can issue a medical order requiring the staff to observe a potentially suicidal inmate more frequently than fifteen minute intervals. In fact, the Lehigh County Prison psychiatrist can order constant observation of a potentially suicidal inmate if he believes that

> 5. The housing unit officer shall document suicide checks on a psychiatric check form and submit it to the medical department at the end of each shift.
>
> 6. Medical staff shall review the check report each shift for significant changes in behavior.
>
> 7. Medical staff will have daily contact with the inmate.
>
> 8. In the event of an official visitor (i.e. attorney, parole officer) the inmate will be dressed and escorted to the appropriate visit area and remain under direct visual observation by the escorting officer.

*See* The Lehigh County Prison Policy 5.5, Suicide Prevention, effective April 20, 2001.

The next level of observation and care under the Suicide Prevention Policy is "medical restraints," which permits, pursuant to a physician's orders, the placement of an inmate in a restraint chair if the inmate exhibits extreme behavior that is or may be harmful to the inmate or others, and a no less restrictive treatment is appropriate. The use of

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this level of observation is required. In addition, the Lehigh County Prison psychiatrist can authorize the commitment of a potentially suicidal inmate under the Pennsylvania Mental Health Procedures Act.

medical restraints is subject to the following conditions:

1. The restraint chair is the only approved form of medical restraint.

2. Staff supervising the placing of an inmate into the restraint chair must be trained in its use.

3. Medical personnel must check the initial application of restraints to ensure circulation is not impaired.

4. The inmate will be dressed in clothing appropriate to temperature unless otherwise specified by the mental health order.

5. Medical staff shall make an assessment every two hours of the inmate's behavior, position, restraints, and health care needs (food, water, elimination, cleanliness) and ensure the needs are met.

6. The housing unit officer shall monitor the inmate at irregular fifteen minute intervals (no more than fifteen minutes between checks).

7. The housing unit officer shall document medical restraint checks on a psychiatric check report form and submit them to the medical department at the end of each shift.

8. Medical staff will review the check report each shift for any significant change in behavior.

9. The housing unit officer shall document each time the inmate is released from medical restraints, or the reason for not releasing the restraints.

10. Medical restraint orders shall not exceed twenty-four hours.

11. Medical restraints shall not be removed without a physician's order with the following exception. The housing unit officer shall remove the restraints every two hours for ten minutes unless the inmate is extremely agitated.

12. The inmate must be monitored continuously when out of medical restraints.

*See* The Lehigh County Prison Policy 5.5, Suicide Prevention, effective April 20, 2001.

The Suicide Prevention Policy also provides for the use of inmate monitors, which are used in the discretion of the medical staff to assist prison staff in directly observing inmates who are on close observations, suicide precautions, and medical

restraints.[11] *See* The Lehigh County Prison Policy 4.5, Inmate Monitors, effective November 26, 2002.

Based upon the record in the within matter, the Lehigh County Prison officials did not ignore or act recklessly with respect to the decedent's suicidal ideations and attempts to kill himself. On the contrary, Lehigh County Prison officials at every stage of the decedent's incarceration made a concerted effort to keep the decedent safe and to stop the decedent from committing suicide. Indeed, the decedent was examined by mental health professionals, including a psychiatrist. Lehigh County Prison officials responded to the decedent's conduct in accordance with the advice and recommendations made by these mental health professionals. The decedent was placed on "suicide precaution" status when warranted and the requirements of the Suicide Prevention Policy, including frequent observation of the decedent and the removal of the decedent's clothing, were followed by the Lehigh County Prison officials. Additionally, the decedent was placed in a restraint when authorized by the mental health professionals and the decedent was placed in a "suicide precaution" cell for appropriate observation.

Overall, the record reflects that the decedent's placement on suicide watch by the medical staff and the decedent's ultimate placement in Cell 3223 were reasonable under the circumstances. Indeed,

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[11]The use of inmate monitors does not, however, relieve prison staff from their responsibility to personally check on the condition of the inmate.

absent a reason to believe, or actual knowledge, that prison doctors or their assistants are mistreating or not treating a prisoner appropriately, a non-medical prison official will not be charged with the Eighth Amendment scienter requirement of deliberate indifference. *Spruill v. Gillis*, 372 F.3d 218, 236 (3d Cir. 2004).[12] The record is void of any evidence to establish that Lehigh County Prison officials knew that Cell 3223 was unsafe and nonetheless chose to utilize it as a suicide precaution cell.[13] In light of Lehigh County

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[12] The record evidence indicates that Defendant Dale Meisel relied on the independent contractor health care provider, Wexford Health Sources, and its physicians, nurses and other health care personnel.

[13] Specifically, the Plaintiffs assert that Cell 3223 was unsafe because it had open bars rather than a clear solid door and because it did not have an adequate sight line. Plaintiffs also complain about the decision of the Lehigh County Prison officials to house potentially suicidal inmates in the Administrative Segregation/Disciplinary Segregation Unit, as well as the decision of the Lehigh County Prison officials not to use constant observation of the decedent. However, the Plaintiffs' claims must fail because they are unable to present evidence to establish that the Lehigh County Prison officials knew that Cell 3223 was unsafe and used it nonetheless. Also, the Plaintiffs have failed to adduce any evidence to establish or raise an inference that the housing of suicidal inmates in the Administrative Segregation/Disciplinary Segregation Unit and/or the use of fifteen (15) minute observation intervals as opposed to constant observation rises to the level of deliberate indifference. Indeed, the decedent was placed on fifteen (15) minute observation intervals based on the decision of medical professionals. The medical professionals could have decided to place the decedent on more frequent observation intervals and the Lehigh County Prison officials would have complied with any directive from the medical professionals. Suicide is a mental health issue and the Lehigh County Prison officials acted appropriately by relying on the advice of mental health

Prison's lack of inmate suicide history, Defendant Dale Meisel had no reason to believe that the medical staff was mistreating suicidal-risk inmates such as the decedent. The record reflects that Defendant Dale Meisel, as a supervisor, acted reasonably with respect to the decedent and his risk of suicide, and decedent's injury does not bear a close causal relationship to Defendant Dale Meisel's alleged failure to respond adequately. Because the record evidence does not directly establish or raise an inference that Defendant Dale Meisel knew that Cell 3223 was unsafe and nevertheless chose to continue to use it as a suicide precaution cell, and examining the record in a light most favorable to the Plaintiffs, Defendant Dale Meisel was not deliberately indifferent to the decedent's risk of suicide. *Cf. Dimitris v. Lancaster County Prison Bd.*, 2002 WL 32348283 (E.D. Pa. 2002) (finding that the Eighth Amendment, applicable to the states under the 14th Amendment, prohibits cruel and unusual punishment of prisoners, thereby entitling them to medical attention for serious health needs and that Section 1983 allows recovery for constitutional violations when a prisoner commits suicide after receiving inadequate attention based on his mental health condition). Accordingly, summary judgment is appropriate as to Defendant Dale Meisel as a matter of law.

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professionals in dealing with the decedent. "Written policy and defined procedures require, and actual practice evidences, that decisions and actions regarding the health care services to inmates are the sole responsibility of qualified health care personnel and are not compromised for security reasons." NCCHC Standards, J-02 Medical Autonomy.

*COUNTY OF LEHIGH:*

This Court notes that a municipality cannot be held liable unless there is a constitutional violation by the municipal actor causing the plaintiff's harm. *Robbins v. Cumberland County Children & Youth Services*, 802 A.2d 1239, 1250-1251 (Pa. Cmwlth. 2002). *See also Mark v. Borough of Hatboro*, 51 F.3d 1137, 1149-1150 (3rd Cir. 1995) (noting that *Collins v. City of Harker Heights*, 503 U.S. 115 (1992) made clear that in the *Monell* case, the proper analysis requires the court to separate two different issues when a 42 U.S.C.A. § 1983 claim is asserted against a municipality: (1) whether the plaintiff's harm was caused by a constitutional violation, and if so, (2) whether the city is responsible for that violation). Thus, the Plaintiffs must establish a breach of a constitutional duty by a state actor before a cognizable claim may be asserted against the County of Lehigh. The Plaintiffs have failed to meet this burden.

As articulated above, the Plaintiffs cannot present evidence at trial that would enable a fact finder to conclude that a state actor violated the decedent's constitutional rights. Because the Plaintiffs cannot establish an underlying constitutional violation, their claim against the County of Lehigh must fail as a matter of law. *See Robbins*, 802 A.2d at 1250-1251.[14] Additionally, this Court recognizes that in *Monell v. Department of Social Services of the City*

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[14] While this Court believes that the analysis should end here and no further discussion is necessary, this Court, nonetheless, will proceed to address Plaintiffs' other claims.

*of New York*, 436 U.S. 658, 694, 98 S.Ct. 2018, 2037-2038 (1978), the Supreme Court held that local government may not be sued under 42 U.S.C.A. §1983 for an injury inflicted solely by its employees or agents. Instead, it is when execution of a government's policy or custom inflicts the injury that the government as an entity is responsible under 42 U.S.C.A. § 1983. *Id.* The Supreme Court has noted the need for a direct causal link between a municipal policy and the alleged constitutional deprivation. *Canton*, 489 U.S. at 385, 109 S.Ct. at 1203. Furthermore, a municipality may only be liable where its policies and/or customs, including training, are deliberately indifferent to others' rights. Canton, 489 U.S. at 388-390, 109 S.Ct. at 1204-1205. Specifically:

> [T]he inadequacy of police training may serve as the basis for § 1983 liability only where the failure to train amounts to deliberate indifference to the rights of persons with whom the police come into contact. . . . [A] municipality can be liable under § 1983 only where its policies are the moving force [behind] the constitutional violation. Only where a municipality's failure to train its employees in a relevant respect evidences a 'deliberate indifference' to the rights of its inhabitants can such a shortcoming be properly thought of as a 'city policy or custom' that is actionable under § 1983. . . . The issue . . . is whether the training program is adequate; and if it is not, the question

> becomes whether such inadequate training can justifiably be said to represent 'city policy.' . . . But it may happen that in light of the duties assigned to specific officers or employees the need for more or different training is so obvious, and the inadequacy so likely to result in the violation of constitutional rights, that the policymakers of the city can reasonably be said to have been deliberately indifferent to the need. In that event, the failure to provide proper training may fairly be said to represent a policy for which the city is responsible, and . . . held liable if it actually causes injury.

*Id.* If the policy or custom does not facially violate federal law, causation can be established only by demonstrating that the municipal action was taken with deliberate indifference as to its known or obvious consequences. *Berg v. County of Allegheny*, 219 F.3d 261, 276, (3d Cir. 2000), *cert. denied*, 531 U.S. 1072, 121 S.Ct. 762 (2001). In the instant case, Plaintiffs' entire municipal liability claim is based upon the County of Lehigh's alleged failure to have in place or adhere to the suggested standards of private organizations in the corrections field. Plaintiffs refer to the American Correctional Association and the National Commission on Correctional Health Care. Specifically, the Plaintiffs essentially seek to hold the County of Lehigh liable on two (2) different theories of relief. First, the Plaintiffs contend that the Lehigh County Prison's Suicide Prevention Policy is deficient

because it does not comply with the standard for prevention of custodial suicide established by the American Correctional Association and the National Commission on Correctional Health Care. In particular, the Plaintiffs allege that the Lehigh County Prison Suicide Prevention Policy is unconstitutional because, contrary to the standards for prevention of custodial suicide established by the American Correctional Association, it does not make provision for the constant observation of suicidal inmates and does not require annual training for correctional officers on suicide prevention. Plaintiffs further assert that the Lehigh County Prison Suicide Prevention Policy is unconstitutional because, contrary to the standards for prevention of custodial suicide established by the National Commission on Correctional Health Care, it does not require uninterrupted monitoring or the transfer of an inmate to a medical facility and does not require a nearly suicide proof cell.

However, the American Correctional Association and the National Commission on Correctional Health Care standards relied upon by the Plaintiffs are not governmental standards or requirements. They are nothing more than recommendations of private organizations in the corrections field that seek to provide accreditation services to jails and prisons. The failure of a correctional facility to comply with the recommended standards means only that the correctional facility would not receive accreditation by the organization in question. At best, noncompliance with the recommended standards could possibly be used to suggest negligence. But as all of the prison suicide cases

make clear, negligence on the part of the prison officials is insufficient to impose liability.[15]

Indeed, in the instant case, there is a dearth of evidence to demonstrate that the relevant policies, practices and customs of Lehigh County Prison constitute deliberate indifference with respect to the decedent's suicide.[16] Similarly, the record is absent of proof that any one on the staff of Lehigh County Prison was deliberately indifferent to the suicide of the decedent, i.e., subjectively disregarding the decedent's suicide risk. *See Farmer*, 511 U.S. at 837, 114 S.Ct. at 1979. In fact, the customs and policies of the Lehigh County Prison meet the National Commission on Correctional Heath Care's Suicide Prevention Standards, and there was no pattern of suicide at Lehigh County Prison prior to the decedent's death to indicate that Lehigh County Prison's suicide prevention policies were problematic.

Based on the foregoing, it is clear that the County of Lehigh and its supervisors had not deliberately chosen to allow suicides, perpetrated a custom of

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[15]Of importance, violation of a recommended standard or failure to adopt a particular standard does not equate to a violation of the constitution so as to support a 42 U.S.C.A. § 1983 claim. *See Bell v. Wolfish*, 441 U.S. 520, 543 (1979).

[16] In order to impose liability on the County of Lehigh, Plaintiffs must present evidence of deliberate indifference on the part of the official or officials with the authority to make municipal policy. *Simmons v. Philadelphia*, 947 F.2d 1042, 1059-1065 (3rd Cir. 1991). The Plaintiffs must show deliberate indifference on the part of a high level official determined by the court to have final policymaking authority in the areas in question. Id., at 1062-1063.

inaction or communicated tacit approval of or acquiescence to inmates' suicides. Rather, express policies were implemented, such as the removal of excess clothing and the checking on inmates at certain intervals to prevent these incidents. Accordingly, summary judgment is appropriate.